

December 22, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1770-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
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**RE: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and COVID-19 Interim Final Rules**

The American College of Radiology (ACR), representing more than 41,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, appreciates the opportunity to provide comments on the 2023 Medicare Physician Fee Schedule (MPFS) final rule.

This letter addresses the following issues within the 2023 MPFS final rule:

- Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology
- Neuromuscular Ultrasound
- Merit-based Incentive Payment System (MIPS) arm of the Quality Payment Program
  - The Performance Threshold
  - Limited Number of Applicable Measures
  - Limiting the Costs of Participation
  - Integration of Other Technological Platforms

**Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology**

***Background***

CMS shared that many commenters requested that they delay any changes to the indirect practice expense (PE) inputs, citing ongoing work by the American Medical Association (AMA) to collect this information via an updated survey to collect this information by P024. CMS has relied on the AMA's physician cost data for over 50 years and has stated that the AMA's 2007/2008 Physician Practice Information Survey (PPIS) has been the best available source of data in calculating indirect PE.

While appreciative of the stakeholder comments, CMS acknowledges that this is a delicate process, and they are not planning to move forward in CY 2023 with any updates to the PE methodology at this time. CMS stresses the importance of the repeatability of any future survey or process to collect this indirect PE data. They will continue to consider possible proposals in future rulemaking.

### ***ACR Perspective and Comments***

The ACR appreciates all the opportunities to provide comments and input into CMS' PE data collection efforts so far. We hope that CMS continues to allow stakeholders the opportunity to share our thoughts related to this effort, as this has the potential to dramatically impact physician reimbursement.

We support CMS' decision to not move forward with updates to the PE methodology in CY 2023. The ACR has been in communication with the AMA on their data collection efforts and have provided feedback to them on their process as well. We strongly believe that any effort—whether by CMS or the AMA—to update the indirect PE inputs should be transparent and accommodate specialty society review and feedback. Practice patterns and structures vary between specialties and even within the same specialty, so it is imperative that the data collection effort reflect this. Similarly, financial officers or business managers should be included in the data collection process to ensure that accurate and complete information is collected for each practice and specialty.

**The ACR recommends that CMS defer any updates to the PE methodology until the AMA completes their data collection effort and shares their results. Moving forward, we agree that the PE inputs should be updated regularly to avoid large swings in reimbursement.**

### **Neuromuscular Ultrasound (Current Procedural Terminology® (CPT) codes 76881, 76882, and 76883)**

#### ***Background***

CMS initially proposed refinements to the physician work relative value units (RVUs) for CPT codes 76881 (*Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation*), 76882 (*Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation*), and 76883 (*Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity*), as well as some practice expense inputs for CPT code 76881. CPT code 76881 is typically billed with evaluation and management (E/M), and CMS believed that there was overlap between the procedures, leading them to remove some of the physician time and clinical staff time for 76881 and reducing the work RVU. This led to decreases in work RVU for the other two codes.

In the final rule, CMS shared that they were swayed by feedback from stakeholders that the pre- and post-service work associated with neuromuscular ultrasound is much more detailed and time intensive than that of an E/M visit. CMS agreed to accept the Relative Value Scale Update Committee (RUC) recommended times and values for the three codes, as well as the practice expense inputs.

In Addendum B, it was noted that CPT codes 76881-76883 only allow for global billing. While CPT code 76883 is new, 76881 and 76882 have always allowed for separate billing of the technical and professional components. There was no language in the rule addressing this change.

### ***ACR Perspective and Comments***

The ACR is pleased that CMS listened to stakeholders regarding the intensity of the neuromuscular ultrasound codes and have agreed to finalize the RUC-recommended work RVUs and practice expense inputs.

However, the ACR is concerned by the unexpected change to the billing of 76881 and 76882 in Addendum B of the final rule, as this was not addressed within the text of the proposed or final rules. In fact, the proposed rule Addendum B reflected technical component (TC) and professional component (PC) reimbursement for CPT codes 76881-76883.

The ACR, along with multiple other specialties, met with CMS staff the first week of December in an effort to clarify any potential misunderstanding about how these procedures are performed by the specialties. In correspondence with CMS staff, they shared that the change was a result of how the codes were redefined at CPT. While CPT code 76883 is a newly created code, 76881 and 76882 are existing. During the CPT process, CPT code 76881 was not changed, while there was only an editorial change to the descriptor of CPT code 76882.

Practice expense recommendations are based on the dominant specialty in the non-facility for each of the three codes. For CPT code 76882, the dominant specialty can fluctuate year-to-year between podiatry and radiology. For example, these codes will be readdressed at the January 2023 RUC, and recent 2021 utilization shows that radiology is now the dominant specialty, while podiatry had higher utilization in January 2022; there is only 2% difference in utilization. Different specialties may utilize different clinical staff and require different “typical” equipment to perform the procedure.

We believe there is also a miscommunication about who typically performs the procedure—whether it is the physician or a technician. For radiology, CPT codes 76881 and 76882 are typically performed by a sonographer with subsequent scanning by the physician, as needed. Currently, for radiologists who work in the hospital setting, the radiologist bills the professional component for their services and the hospital bills the technical component for reimbursement. With CMS changing these codes to only allow for the global to be billed, this has the potential to

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create billing complications and denials for radiologists and hospitals. We are quickly approaching CY 2023 and, given that this change was not addressed in the proposed rule, the ACR does not feel there is now sufficient time to educate our members on this new billing pattern for this family of codes. **The ACR urges CMS to reinstate -TC and -PC reimbursement for CPT codes 76881 and 76882.**

### **Merit-based Incentive Payment System (MIPS) arm of the Quality Payment Program**

#### *The Performance Threshold*

The ACR urges CMS to seek some method of mitigating the statutory requirement that sets the MIPS performance threshold to the mean or median of a prior year's actual scores to earn a positive payment adjustment. In light of the 2019, 2020, and 2021 performance years' extreme and uncontrollable circumstances exemptions affecting CMS' ability to calculate the performance threshold accurately, **we recommend changes to CMS scoring policies so that action may be taken to lessen the negative impact of this high-performance threshold.** For instance, scoring and benchmarking could occur within specialties only, with radiologists' scores compared against other radiologists. Though this could result in more radiologists scoring below the performance threshold, the ACR suggests moving from decile and benchmark scores to implementing a reasonably achievable total score value which would see the majority of participants earning positive payment adjustments while those practices not doing the work receive a negative adjustment.

Over the past two years, many clinician or physician practices, including radiology groups, at risk of falling below the neutral performance threshold did not participate in MIPS, indicating that performance data from these periods are likely unreliable for calculating future thresholds. Due to the rising performance threshold, the removal of quality measure bonus points, and the increasing number of quality measures capped at seven points or removed from the program, it is difficult for many radiologists to achieve a neutral adjustment even when performing well on quality measures. Beginning in the 2022 MIPS performance year and continuing in 2023 MIPS, participants will be held to a standard derived from 2017 performance data, even though in 2017 a high MIPS score was significantly more attainable.

#### *Limited Number of Applicable Measures*

As mentioned, some medical specialties and subspecialties, like radiology, do not immediately fit MIPS's "one-size-fits-all" model. In particular, diagnostic radiologists, designated by CMS as non-patient-facing physicians, are commonly exempt from the Cost and Promoting Interoperability (PI) performance categories under traditional MIPS and eventually MIPS Value Pathways (MVPs), with their MIPS scores primarily determined by their Quality category scores. **Radiologists without attributed cost or promoting interoperability measures will have their Quality category score weighted at 85 percent, with the Improvement Activities (IA) category remaining at 15 percent. However, CMS regulations impose a seven-point topped-**

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**out measure cap, making it nearly impossible to meet the neutral performance threshold even with perfect performance on six topped-out quality measures. The ACR supports an increase to the category weight assigned to the IA which would support radiology participants.**

**There is potential for MIPS-participating radiology practices to perform perfectly on their quality measures but score below the MIPS performance threshold because of limitations imposed by the dwindling number of radiology-focused MIPS clinical quality measures (CQMs) and capped measure scores.** For example, of the seven MIPS measures in the Diagnostic Radiology Specialty Measure Set, only one is not capped at seven points. Practices scoring perfectly on the single 10-point measure and five of the seven-point capped measures would achieve a Quality category score of 45 out of 60 points (75 percent). If the Quality category equates to 85 percent of their total score, and they score perfectly in the Improvement Activities category, these practices will achieve a MIPS final score of 79 points. Such a score narrowly avoids the negative payment adjustment with the performance threshold set at 75 points. Therefore, these practices would receive a financial penalty for scoring less than perfect or if the threshold is increased to 80 points. The ACR is troubled that the regulations intended to support the Quality Payment Program (QPP) goals of providing high-quality, value-driven care are diminished by penalizing practices that are anything short of perfect on these few select measures, and particularly so, without consideration of a formal quality improvement framework that may be ongoing in the practice that could result in continued and substantial increments of improved quality or broadening of care inclusion. **The ACR stresses that penalizing high-performing practices with negative payment adjustments contradicts MIPS' goals and alienates participants.**

**We strongly suggest that CMS work with medical specialty societies to ensure that high-performing practices earn scores demonstrative of their performance in the Quality category rather than penalizing them because regulation prevents them from achieving their actual high scores.**

#### *Limiting the Costs of Participation*

Having consulted with ACR MIPS-participating members and after examining several publications, ACR analysis confirms that MIPS participation can cost radiology practices per National Provider Identifier (NPI) an average of \$12,881.00 (+/- \$5,000) per year and requires about 200 combined physician and clinical staff and administrative staff hours per year.<sup>1</sup> Examining these factors for medium-sized practices (those not awarded with small and rural practice bonuses or participation flexibilities and who do not have the support of a large institution) comprising 15 to 30 diagnostic radiologists, those with 15 saw costs increase to \$193,215.00 (+/- \$5,000) and \$386,430 for practices with 30 radiologists. Given these costs and

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<sup>1</sup> Khullar, D, Bond, AM, O'Donnell, CM, Qian, Y; Gans, DN, Casalino, LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System  
A Qualitative Study. *JAMA Health Forum*. 2021;2(5):e210527. doi:[10.1001/jamahealthforum.2021.0527](https://doi.org/10.1001/jamahealthforum.2021.0527)

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the decreased likelihood of radiologists achieving more than the 75-point performance threshold, practices furnishing services under Medicare will only lose money.

### *Value for Radiologists to Participate in MIPS*

The ACR is committed to supporting the delivery of high-quality care through quality improvement programs, education, and advocacy. We also understand CMS' effort to provide high-value care considering the patient outcomes and costs of the services delivered. However, given the difficulties for diagnostic radiologists to meet traditional MIPS and MVP requirements, combined with the associated costs, we are troubled by the potential disinterest of radiologists eligible to participate in MIPS. For instance, since most of these physicians cannot participate in the Cost and Promoting Interoperability performance categories due to the measures' attribution methodologies, we are left wondering about the value of MIPS for these physicians. If only to ensure participation in quality measurement and improvement activities (i.e., quality improvement).

**The ACR also recommends expanding the cost measures supported by the Cost performance category to include measures that are not limited to care episodes or tied strictly to the models of assessment and attribution of cost that CMS uses. Given diagnostic radiologists' role on care teams, radiology episodes are uniquely defined. The ACR proposes CMS seek quality measures that would serve as proxies for cost measurement. Examples include appropriate imaging use or imaging efficiency measures.**

### *Integration of other technological platforms*

CMS must also recognize that most radiologists capture clinical data daily in practice using electronic platforms and sophisticated technology other than certified electronic health record technology (CEHRT). This advanced use of technology, including artificial intelligence (AI), and innovative methods for integrating disparate information systems supports improved care coordination and patient care – beyond the use of CEHRT – and should be recognized. It is important to note that all MIPS clinical quality and Qualified Clinical Data Registry (QCDR) measures are specified for use in registries, not electronic health records. **The ACR recommends that CMS integrate clinical and administrative data captured through alternate electronic platforms, like picture archiving and communication systems (PACS) or imaging equipment with sophisticated software and analytics integrated, in the PI performance category.**

### **Conclusion**

The ACR appreciates the opportunity to provide comments on the CY 2023 MPFS final rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process in order to create a stable and equitable payment system and promote an equitable delivery system. The ACR looks forward to continued dialogues with CMS officials



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about these and other issues affecting radiology and radiation oncology. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Kathryn Keysor at [kkeysor@acr.org](mailto:kkeysor@acr.org).

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "William T. Thorwarth Jr.", written in a cursive style.

William T. Thorwarth Jr., MD, FACR  
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