American College of Radiology

September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1786-P
P.O. Box 80010
Baltimore, MD 21244–1850

Re: CMS-1786-P: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction

Dear Administrator Brooks-LaSure:

The American College of Radiology, representing over 40,000 diagnostic, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) calendar year 2024 proposed rule on Hospital Outpatient Prospective Payment (HOPPS) and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.

The ACR provides comment on the following important issues:

1. Proposed APC Placement of Newly Established CPT Codes
2. Cardiac Computed Tomography Reimbursement
3. OPPS Payment for Software as a Service
4. Payment Policy for Diagnostic Radiopharmaceuticals
5. Hospital Outpatient Quality Reporting (OQR) Program New Measure
6. HCPCS C-Code Creation

Proposed APC Placement of Newly Established CPT Codes

Proposal
CMS proposes to place newly established CPT codes 2X000 and 7X005 in the following APCs:

HEADQUARTERS
1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900

CPT Code	CPT Long Descriptor	CY 2024 Proposed APC	CY 2024 Proposed Status Indicator	CY 2024 Proposed Reimbursement
2X000	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device	5116 – Level 6 Musculoskeletal Procedures	J1	$20,692.25
7X005	Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	5724 – Level 4 Diagnostic Tests and Related Services	S	$1,009.24

ACR Perspective and Comments
The ACR would like to thank CMS for the opportunity to share ACR's recommendations for the placement of newly established CPT codes into appropriate APCs for CY 2024. ***The ACR is pleased CMS agreed with the ACR's recommendation for the APC placement of the new CPT code 2X000 into APC 5116 and 7X005 into APC 5724 due to clinical similarity and resource use to the respective predecessor codes 0755T and 0501T-0504T***.

Cardiac Computed Tomography Reimbursement

Proposal
The three codes 75572, 75573, and 75574 that describe cardiac CT studies are proposed to be placed in APC 5571 with a reimbursement rate of $177.09 for CY 2024.

ACR Perspective and Comments
The CY 2024 HOPPS proposed rule again neglects to appropriately address the flawed

methodology that results in inadequate Medicare reimbursement rates for these services, ultimately limiting Medicare beneficiary access to care. The ACR does not agree with CMS' placement of cardiac CT codes 75572, 75573, and 75574 into APC 5571. These codes require substantially more time and resources than any of the tests assigned to APC 5571. ***Cardiac CT should be reassigned to APC 5572 to bring into better alignment with clinical homogeneity and cost/resource utilization*.**

CPT Code	CPT Short Descriptor	CY 2024 Proposed APC	CY 2024 Proposed Reimbursement	ACR Recommended CY 2024 APC	ACR Recommended CY 2024 Reimbursement
75572	Ct hrt w/3d image	5571 – Level 1 Imaging with Contrast	$177.09	5572 – Level 2 Imaging with Contrast	$369.86
75573	Ct hrt c+ strux cgen hrt ds	5571 – Level 1 Imaging with Contrast	$177.09	5572 – Level 2 Imaging with Contrast	$369.86
75574	Ct angio hrt w/3d image	5571 – Level 1 Imaging with Contrast	$177.09	5572 – Level 2 Imaging with Contrast	$369.86

Cardiac CT exams require more time, require highly trained technologists who reformat non-orthogonal projections, involve higher risk patients, require administration of vasoactive medications, and require close monitoring of patients during and after the procedure. The need for all these resources is vastly different from other contrast-enhanced imaging studies in 5571 which are less resource intensive and may only take a fraction of the time. Moreover, this test has been shown to be highly cost-effective in evaluating acute chest pain in the emergency setting by reducing hospital admissions and precluding the need for costlier interventional procedures. APC misallocation will only serve to stunt further adoption. ***The ACR requests that CMS exercise its authority to move 75572, 75573, and 75574 contrast-enhanced cardiac CT codes to APC 5572 to ensure beneficiary access to guideline-driven care and eliminate health inequities in cardiac care*.**

<u>OPPS Payment for Software as a Service</u>

Proposal

CPT codes 0648T and 0649T, which report Q-MR procedures, are proposed to be reassigned from APC 1511 (New Technology Level 11) to APC 1505 (New Technology Level 5) with the application of the universal low volume APC policy, using the arithmetic mean to set the proposed updated reimbursement rate. SaaS code 0625T (Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using

data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography) is proposed to maintain the same APC from CY 2023 to CY 2024 despite being below the low volume threshold with 90 claims from CY 2022.

ACR Perspective and Comments

The ACR believes that CMS should allow for more claims data to accrue before reassigning Software as a Service codes. Refinements and exclusions based on low claims volumes should be applied consistently throughout the current fee schedule and across years. This would allow for more stability within the HOPPS with constantly emerging AI technologies to come.

Lastly, it is pertinent for CMS to clarify that the SaaS codes for qCT, qMR, and qUS were designed by CPT to be vendor neutral, and that these codes do not belong to any single vendor or represent any single vendor's services.

Payment Policy for Diagnostic Radiopharmaceuticals

Proposal

Under the OPPS, CMS packages several categories of non-pass-through drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the products. Diagnostic radiopharmaceuticals, which include contrast agents, are one type of product that is policy packaged under the category described by § 419.2(b)(15). CMS solicited comments on several potential approaches that would enhance beneficiary access while maintaining the principles of the OPPS.

For CY 2024, CMS is seeking comments on potential modifications to its packaging policy for diagnostic radiopharmaceuticals. Specifically, CMS is seeking comments on the following new approaches to payment of diagnostic radiopharmaceuticals under the OPPS:

1. Paying separately for diagnostic radiopharmaceuticals with per-day costs above the OPPS drug packaging threshold of $140;
2. Establishing a specific per-day cost threshold that may be greater or less than the OPPS drug packaging threshold;
3. Restructuring APCs, including by adding nuclear medicine APCs for services that utilize high-cost diagnostic radiopharmaceuticals;
4. Creating specific payment policies for diagnostic radiopharmaceuticals used in clinical trials; and
5. Adopting codes that incorporate the disease state being diagnosed or a diagnostic indication of a particular class of diagnostic radiopharmaceuticals.

ACR Perspective and Comments

The ACR appreciates the opportunity to provide feedback regarding the reimbursement of diagnostic radiopharmaceuticals within the HOPPS. We acknowledge that CMS put forth an array of potential payment reforms to modify the current payment policy in the outpatient

setting. The current packaging policy has negatively impacted access to advanced diagnostic tools for patients, especially for hospitals with high percentages of Medicare beneficiaries. ***The ACR recommends that CMS establish separate payment for diagnostic radiopharmaceuticals including a per day cost threshold based on ASP+6% methodology.*** We believe that separate payment is the best policy and that it is pertinent for CMS to implement this new methodology beginning with CY 2024 to allow for appropriate reimbursement and to improve access. The ACR also supports the "Facilitating Innovative Nuclear Diagnostics Act (FIND Act) of 2023" (H.R. 1199/S. 1544) for PET radiopharmaceuticals, which would retain policy packaging for generic radiopharmaceuticals that are fully reimbursed through the bundled payment and simultaneously ensure that hospitals receive adequate reimbursement to provide the best available diagnostic tools to patients.

Hospital Outpatient Quality Reporting (OQR) Program New Measure

Proposal
CMS proposes to adopt the "*Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient)"* eCQM beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

ACR Perspective and Comments
The ACR has concerns about the proposed "Excessive Radiation Dose or Inadequate Image Quality" measure as we provide below, many of which were also outlined in our comments on the Fiscal Year (FY) 2024 Hospital Inpatient Prospective Payment System (IPPS) and CY 2024 Medicare Physician Fee Schedule proposed rules. First, we would like to emphasize that the ACR is a strong advocate and proponent for patient radiation safety as demonstrated by the multiple and various ongoing efforts and activities in which the organization and the radiology community are involved (i.e., guidelines and technical standards, imaging appropriateness criteria, the Image Gently and Image Wisely alliances and campaigns, radiation safety manuals, accreditation, dose index monitoring and management, educational products, publications, and performance measures). The ACR fully supports entities or individuals that put forward valid and feasible tools to optimize patient exposure to radiation through dose monitoring and imaging appropriateness.

The ACR also supports CMS's efforts to prioritize radiology-focused patient safety eCQMs that address patient outcomes. However, we caution CMS with finalizing this measure in the Hospital Outpatient Quality Reporting (HOQR) program for use beginning with the CY 2025 reporting period, and strongly recommend against mandatory reporting in CY 2026 as an extremely premature requirement for the reasons discussed below.

Implementation challenges, burden and timeline

This measure necessitates considerable organizational efforts to access and process the data elements required to calculate the measure score. The complexity of the measure, particularly concerning methods for calculated data elements, requires the creation of measure software and logic by hospital staff or the use of a commercial product. Currently, the only software for implementing this eCQM was created and maintained by a single commercial vendor, Alara Imaging Inc., in conjunction with the measure steward. The measure steward has affirmed that organizations may obtain access to a version of the software without charge. However, just because the vendor provides a free version does not mean that there will be no cost to radiology providers.

While the ACR sees inclusion of this measure within the Hospital Outpatient Quality Reporting (HOQR) program, and less so the Hospital Inpatient Quality Reporting (IQR) as supportive to radiology groups' that may wish to use the corresponding clinician level "Excessive Radiation Dose" measure in the MIPS program, the timeframe proposed by CMS for adoption of the measure in the HOQR program as voluntary, but especially as mandatory is premature. The mandatory reporting requirement of two years out presumes that hospital outpatient departments and centers have the resources to dedicate or re-prioritize to implementing the measure rapidly.

There may not be a cost to obtaining the Alara software but there is a resource cost to integrating it into existing technology such as the EHR, RIS or PACS. Healthcare IT staff are always cognizant of security concerns implementing software products as well as ongoing management.

Regardless of in-house or commercial solutions, healthcare IT staff who are likely already juggling multiple technological priorities, software upgrades, transitions, or installations will be tasked with implementing the proposed measure. Additionally, hospitals may need to provide the ability for radiology groups to access detailed clinician/group level performance data (with the idea of using it to improve) which will be necessary for radiologists to report the measure if this is implemented in MIPS. Hospital operational staff will need to oversee installation, configuration, and ongoing management of any measure software, commercial or proprietary. Software configuration requires mapping or extracting data element components from the relevant systems necessitating connections across systems, determining the source for CPT/ICD codes used to classify an exam for the CT Category field values (extracted from an EHR, billing/practice management system, or a radiology information system (RIS), as well as radiation dose and global noise values (size-adjusted dose and image quality) to determine measure performance. Thus, total costs to organizations to implement the software could be high—regardless of the price of the software.

Additionally, LOINC codes created for the measure calculated fields exist but may not necessarily be used by every institution or facility; capturing data for the new codes will need to

be configured. The LOINC codes do not rely solely on standardized fields from a system; any system that implements the fields must embed some calculations. For instance, there is a DICOM field for patient size for calculating size-adjusted doses, however, it is frequently null. Most radiation dose monitoring tools calculate patient size from CT images. Hospital staff (or other software vendors) who implement the measure will have questions regarding the exact, step-by-step methods for calculating patient size, size-adjusted dose, or global noise calculation, none of which have been provided. Will Alara Imaging Inc. or the measure steward provide detailed information to answer such questions?

Although the proposed "Excessive Dose" measure was tested at multiple pilot sites of varying facility types specified, the ACR has much more experience extracting similar data from more than 2,500 facilities utilizing the ACR Dose Index Registry that have submitted over 193 million CT exams or that have undergone ACR CT Accreditation. Through such experience with these facilities, we have found that the ability to extract these data elements and transform them into the calculated fields with any degree of accuracy or consistency even with an available software solution is far from trivial. We have serious concerns about the feasibility of this approach.

The ACR also has concerns regarding the measure implementation impact on rural hospitals and those treating underserved communities, given their already limited resources; implementing this measure in these care settings may prove insurmountable for many.

Measure methodology

ACR is concerned with the lack of demonstrated validity or reliability supporting the measure, particularly with using the calculated fields. The data elements needed for the measure are calculated using multiple structured fields within the EHR and the radiology electronic clinical data systems, including the Radiology Information System (RIS) and the Picture Archiving and Communication System (PACS).

CT Dose and Image Quality Category (CT Category)

The accuracy and specificity of CPT/ICD codes to determine the true indication for an exam at the time of order is a cause for concern. Indications for exams at the time of order do not typically have standardized language that could be used to categorize the CT exam purpose (CT Category) nor fully characterize the patient's condition. As a result, the clinical reason for performing an imaging exam is often extremely limited within the exam order, even if using an ICD 10 code. For example, an order for CT abdomen with an indication of "pain" may use a low dose kidney stone or a routine CT protocol. Most health and IT systems capture CPT and ICD-10 coding for reimbursement, but codes are typically assigned after the imaging exam's completion. Since the imaging exam is a diagnostic tool to support the final diagnosis by the treating physician, which likely includes other factors, ICD and CPT codes assigned at that point would serve only as a proxy for the understood indication at the time of the imaging exam. This is a particular problem if the exam is normal/negative for the suspected condition. Additionally,

EHR systems are notoriously incomplete, lacking this type of information, and interoperability issues may exist with other software systems containing such information, like billing/coding systems.

CT Size-Adjusted Dose and CT Global Noise

The two primary components of the proposed measure, "CT size-adjusted dose" and "CT global noise" are not widely accepted image quality measurements nor have they been widely tested and validated. CT noise measurements are especially problematic, as finding a reliable measure of image noise that can be taken directly from the image has proven elusive over the decades, despite a number of the world's foremost labs pursuing this in earnest for many years. The fact that Alara Imaging Inc. has proposed a proprietary version that has not been released for public review makes it difficult to verify the validity and reliability of the global noise methodology.

Actionability/Usability

The imaging protocol selection appropriate for a clinical indication is a crucial factor in radiation dose management and optimization. It requires that each component be addressed as a separate quality action. The most accurate way to address the appropriate and safe use of multi-phase CT studies is to measure the clinical indication of an exam and the radiation output (dose indices) per exam and assess the two separately or distinctly together. However, this measure conflates the appropriateness of the protocol for the clinical indication and radiation dose optimization, disregarding applicability, from which a facility may be unable to determine if adjusting protocols or focusing on the appropriateness of the exam ordered could improve performance. Therefore, improvement may be limited.[1] Consider the following practical examples:

- Should the protocol always be adjusted because of patient size if the dose index value is high on a specific exam?
- The exam may have been inadequate for image quality, as shown by measure results, but the physician was comfortable making a diagnosis using the images. How does that relate to the image quality benchmark? Again, in cases with broad indications such as "pain", the protocol selection may vary i.e., low dose kidney stone or a routine CT protocol.
- What is an appropriate radiation dose index benchmark for routine abdomen CT for a patient weighing 300 lbs.?

These are just a few of the many unanswered (and potentially unanswerable) questions that have not been addressed. The ACR strongly believes that it is premature to require providers across the country to measure performance on "excessive radiation dose" based on clinical indication thresholds until more advanced national benchmarks are standardized and available.

Use of the term "excessive radiation dose"

The term "excessive radiation dose" is subjective, imprecise, inaccurate, and alarmist. Additionally, the phrase could be misused in an unwarranted medico-legal action. The effort to inform patients regarding risks of ionizing radiation while reassuring them that the risks are low is a delicate balance. Terminology matters a great deal, as has been highlighted by many prominent experts, especially those leading the Image Gently campaign. The ACR has developed numerous educational and guidance materials on radiation dose safety. Of note, our communications and guidance balance providing patients and clinicians with awareness of the risk associated with radiation exposure and the incredible benefits medical imaging provides to patient care. We carefully craft statements so as not to raise undue alarm or fear of potential life-saving clinical care. Terms such as "optimization" or "dose lowering" are preferable to those such as "excessive dose" and using the term "excessive dose" may be inaccurate and unnecessarily alarmist.

Healthcare community understanding

The ACR recognizes that the "Excessive Radiation Dose" measure has received substantial support across the medical and healthcare community, including from numerous radiology groups and leadership within the specialty. Based on input received from multiple contacts, we believe that a majority or large percentage of commenters support the general concept of addressing radiation dose optimization by indication for exam, which the ACR also supports, while not understanding the details of the measure approach or methods for implementation. We strongly encourage that CMS reach out to various stakeholders supporting the measure to gauge comprehension of the measure details and implementation logistics.

The ACR fully supports valid and feasible tools to optimize patient exposure to radiation dose. However, we strongly recommend that CMS take a considered approach to implementing the "Excessive Radiation Dose" measure into the HOQR program, allowing a period for larger-scale testing, implementation, and experience with the measure before including it for the CY 2024 reporting period, merely months away. The ACR also urgently requests that CMS rename the measure to remove the misinforming phrase "excessive radiation dose" and use less alarmist language such as "optimized dose".

The ACR appreciates the opportunity to provide comments on the CMS proposal to include the "*Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults" (Hospital Level-Outpatient)* eCQM into the HOQR program. As stated in our introduction, the ACR is a strong advocate and proponent for patient radiation safety, as demonstrated by our many efforts, alliances, and collaborations. As evidenced by numerous commenters during the measure review process, many in the healthcare community strongly support programs and efforts for optimization and management of radiation dose associated with medical imaging. Although the ACR has outlined various concerns with the proposed

measure, we are aligned with its goal. We seek to work in partnership with this stakeholder community and CMS to identify and implement measures addressing radiation dose and safety that are methodologically and scientifically sound, provide meaningful feedback and improvement opportunities, have transparent data collection and calculation methods, and are as least burdensome as possible. We hope these comments provide valuable input for your consideration.

1 Mahesh M. Benchmarking CT Radiation Doses Based on Clinical Indications: Is Subjective Image Quality Enough? Radiology. 2021 Nov 9:212624.

HCPCS C-Code Creation

The ACR respectfully disagrees with the C-code creation and descriptors listed below. We request that CMS delete these codes or change the descriptors to be consistent with the current CPT code descriptors. In 2014, CPT codes 19081-19086 bundled the procedure codes 19102 and 19103 with codes 77031, 77032, 76098, and 19295 to describe breast biopsy procedures. As stated in the 2023 CPT code book, page 108:

> "When more than one percutaneous breast biopsy with or without localization device placement is performed using the same imaging modality, use an add-on code whether the additional service(s) is on the same or contralateral breast. If additional percutaneous biopsies with or without localization device placements are performed using different imaging modalities, report another primary code for each additional biopsy with or without localization device placement performed using a different image guidance modality.
> To report bilateral image-guided breast biopsies, report 19081, 19083, 19085 for the initial biopsy. The contralateral and each additional breast image-guided biopsy are then reported with 19082, 19084, 19086."

In 2023, Medicare created breast biopsy codes (C7501 and C7502) for patients in the OPPS setting. These C code descriptors for percutaneous breast biopsies are inclusive of "**all lesions unilateral and bilateral.**" Creating these C codes prevents reporting and separate payment for each additional biopsy(ies) on the same or contralateral breast.

EXAMPLE
Patient with an area of architectural distortion in the lower outer quadrant of the left breast and pleomorphic microcalcifications in the upper outer quadrant of the same or contralateral breast using stereotactic guidance for both lesions.

For a Medicare OPPS patients, one would report:

C7501 - Percutaneous breast biopsies using stereotactic guidance, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral and bilateral (for single lesion biopsy, use appropriate code)

For non-Medicare, commercial payers, in an OPPS setting, one would report:

19081 - Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance

19082 - Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

Similarly, the vertebroplasty and vertebral augmentation C codes (C7504, C7505, C7507, and C7508), differ from CPT code combinations 22510/22511 and 22513/22514, as the C codes include the **first and any additional vertebral bodies.** As stated in the 2023 CPT code book:

> "Use one primary procedure code and an add-on code for additional levels."

The creation of these C codes prevents accurate reporting and appropriate reimbursement for vertebroplasty and vertebral augmentation, specifically for those cases in which the procedure must be performed on multiple levels.

EXAMPLE
For a Medicare OPPS patients, a percutaneous vertebral augmentation performed at 2 thoracic levels with bilateral cannulation would be reported only as:

C7507 - Percutaneous vertebral augmentations, **first thoracic and any additional thoracic or lumbar vertebral bodies**, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), **unilateral or bilateral** cannulations, inclusive of all imaging guidance

For non-Medicare, commercial payers, in an OPPS setting, one would report:

22513 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22515 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

The new C-code descriptors would likely lead to the performance of separate procedures on separate dates of service. This would not only be inconvenient for patients, but also represents a significant patient safety risk. For these reasons, we ask that CMS delete these codes or change the descriptors to be consistent with the current CPT code descriptors.

C-Code	C-Code Descriptor	Current CPT Code	Current CPT Code Descriptor
C7501	Percutaneous breast biopsies using stereotactic guidance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, **all lesions unilateral and bilateral** (for single lesion biopsy, use appropriate code)	19081 and 19082	**19081**- Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance **19082**- Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)
C7502	Percutaneous breast biopsies using magnetic resonance guidance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, **all lesions unilateral**	19085 and 19086	**19085**- Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance

	or bilateral (for single lesion biopsy, use appropriate code)		**19086**- Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)
C7504	Percutaneous vertebroplasties (bone biopsies included when performed), **first cervicothoracic and any additional cervicothoracic or lumbosacral** vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	22510 and 22512	**22510**- Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic **22512-** Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
C7505	Percutaneous vertebroplasties (bone biopsies included when performed), **first lumbosacral and any additional cervicothoracic or lumbosacral** vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	22511 and 22512	**22511**- Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral **22512**- Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

C7507	Percutaneous vertebral augmentations, **first thoracic and any additional thoracic or lumbar** vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	22513 and 22515	**22513**- Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic **22515**- Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
C7508	Percutaneous vertebral augmentations, **first lumbar and any additional thoracic or lumbar** vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	22514 and 22515	**22514**- Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar **22515**- Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

The ACR appreciates the opportunity to comment on the CY 2024 HOPPS proposed rule. We hope you find these comments provide valuable input for your consideration. For any questions, please contact Kimberly Greck (kgreck@acr.org) or Christina Berry (cberry@acr.org).

Respectfully submitted,

William T. Thorwarth Jr., MD, FACR
Chief Executive Officer

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