

September 6, 2024

Chiquita Brooks-LaSure, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: Medicare and Medicaid Programs: CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Proposed Rule; CMS-1807-P

Dear Administrator Brooks-LaSure:

The American Association of Physicists in Medicine (AAPM)<sup>1</sup> is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 31, 2024 *Federal Register* notice regarding the 2025 Medicare Physician Fee Schedule (MPFS) proposed rule.

### **Reduction to the 2025 Conversion Factor**

The proposed 2025 Conversion Factor is \$32.3562, a significant 2.8 percent decrease over the final 2024 Conversion Factor of \$33.2875.

Radiation oncology services have experienced MPFS payment reductions of more than 25 percent over the past decade. We are very concerned regarding the additional payment reductions proposed for 2025. Payment cuts of this magnitude are unsustainable and fail to recognize that radiation oncology is a high-value form of cancer treatment. Major reforms to the conversion factor update policy are necessary to achieve payment stability to ensure accessible high quality cancer care.

The AAPM urges CMS to protect access to radiation oncology by mitigating payment cuts and ensuring that Medicare payments keep pace with inflation. We believe that underlying issues with MPFS methodology and staggered practice expense changes negatively impact access to high-value radiation oncology services.

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<sup>1</sup> The American Association of Physicists in Medicine (AAPM) is the premier organization in medical physics, a broadly-based scientific and professional discipline encompassing physics principles and applications in biology and medicine whose mission is to advance the science, education and professional practice of medical physics. Medical physicists contribute to the effectiveness of radiological imaging procedures by assuring radiation safety and helping to develop improved imaging techniques (e.g., mammography CT, MR, ultrasound). They contribute to development of therapeutic techniques (e.g., prostate implants, stereotactic radiosurgery), collaborate with radiation oncologists to design treatment plans, and monitor equipment and procedures to insure that cancer patients receive the prescribed dose of radiation to the correct location. Medical physicists are responsible for ensuring that imaging and treatment facilities meet the rules and regulations of the U.S. Nuclear Regulatory Commission (NRC) and various State regulatory agencies. AAPM represents over 9,000 medical physicists.

## **Valuation of New Magnetic Resonance Examination Safety Procedures**

In September 2023, the CPT Editorial Panel created a new code family to describe magnetic resonance (MR) examination safety procedures and capture the physician work involving patients with implanted medical devices that require access to MR diagnostic procedures (CPT codes 7XX00-7XX05).

### *WORK RVUS:*

**The AAPM agrees with the CMS proposal to accept the RUC-recommended work RVU of 0.60 for CPT code 7XX02, work RVU of 0.76 for CPT code 7XX03, work RVU of 0.75 for CPT code 7XX04, and work RVU of 0.60 for CPT code 7XX05.**

### *PRACTICE EXPENSE RVUS:*

CMS proposed several refinements to the direct practice expense inputs for MR examination safety procedure codes 7XX00 through 7XX05.

1. CMS proposes to refine the equipment time for ED053 (Professional PACS Workstation) from 13 minutes to 0 minutes for CPT code 7XX03 as a facility practice expense input. CMS believes this was an unintended technical error.

**The AAPM supports the CMS proposed refinement and agrees that there should not be any facility inputs for CPT code 7XX03, including equipment time for ED053.**

2. CMS proposes to refine the clinical labor time for the CA024 activity (Clean room/equipment by clinical staff) from 2 minutes to 1 minute for CPT codes 7XX04 and 7XX05, which results in a proposed decrease to the equipment time for EL008 (Room, MR) and EQ412 (Vitals monitoring system (MR Conditional)) by 1 minute.

**The AAPM agrees with the reduction in CA024 time from 2 minutes to 1 minute, thereby resulting in a 1-minute reduction to EL008 and EQ412 equipment time for CPT codes 7XX04 and 7XX05.**

The AAPM has concerns regarding several CMS proposed refinements to the direct practice expense (PE) inputs.

1. CMS proposes to refine the clinical labor rate for CA034 activity (Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)) performed by the MRI technologist from 2 minutes to 1 minutes for CPT codes 7XX00, 7XX01, 7XX02, 7XX04, and 7XX05.

**The AAPM disagrees with the CMS proposed refinement for CPT codes 7XX00, 7XX01, 7XX02, 7XX04 and 7XX05.**

- CPT 7XX00: 2 minutes is necessary because the technologist must write a detailed report to include evaluated implant components, MR conditions for requested exam, implant programming requirements, special positioning requirements, acceptable radiofrequency coils, and necessary personnel for the exam. The written report will also typically include assessment of eligibility to schedule MR exam including whether exam is declined or requires risk/benefit analysis, with rationale, so that these steps will not need to be repeated in the future. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete

documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.

- CPT 7XX01: 2 minutes is necessary because the technologist must write a detailed report to include evaluated implant components, MR conditions for requested exam, implant programming requirements, special positioning requirements, acceptable radiofrequency coils, and necessary personnel for the exam. The written report will also typically include assessment of eligibility to schedule MR exam including whether exam is declined or requires risk/benefit analysis, with rationale, so that these steps will not need to be repeated in the future. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.
  - CPT 7XX02: 2 minutes is necessary because the technologist must write a detailed report to include evaluated implant components, MR conditions for requested exam, implant programming requirements, special positioning requirements, acceptable radiofrequency coils, and necessary personnel for the exam, as determined from the clinical determination of the physician. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.
  - CPT 7XX04: 2 minutes is necessary because the technologist must write a detailed report to include clinical staff records with information about the program settings and outputs used during the MR procedure, and status of implant after the exam. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.
  - CPT 7XX05: 2 minutes is necessary because the technologist must write a detailed report to include clinical staff records with information regarding patient tolerance of head wrap and implant status post procedure to inform future scheduling of MR procedures. 7XX03 only requires 1 minute because the medical physicist typically documents the 7XX03 procedure in tandem with performance of the MR procedure and needs less time to complete documentation at completion of the procedure. The CA032 (scan into PACS) activity for reference code 70543 is not comparable.
2. CMS proposes to refine the clinical labor for the CA021 activity (Perform procedure/service---NOT directly related to physician work time) from 27 minutes to 14 minutes for CPT code 7XX01. This proposed refinement would result in a reduction to the equipment time for the Technologist PACS workstation (ED050) from 45 minutes to 32 minutes.

**The AAPM disagrees with the proposed reduction of CA021 activity time, and the resulting decrease in ED050 equipment time for CPT 7XX01.**

The typical work for 7XX01 involves assessment of an implant where there may be no implant information readily available in the medical chart or the patient does not have access to their implant card. We believe there is significantly more work for the technologist in 7XX01 compared to 7XX00 because the technologist typically calls the patient's primary care physician's office to obtain more

information about who inserted the implant and then contacts the relevant physician's office to send information related to the patient's implant to review or asking questions to obtain as much detail as possible as regarding the implant. Information such as date of insertion, location, component model numbers, and if there have been subsequent revision surgeries to the original implant. This is significantly more work than the 7XX00 code, which may be confined to review of the medical chart and/or a call to the patient directly who will have the implant information available.

3. CMS proposes to remove supply item SL082 (impression material, dental putty (per bite block)) from CPT code 7XX05

**The AAPM disagrees with the CMS proposal to remove supply code SL082 for CPT code 7XX05.**

The impression putty is a component of the applied splint and compression bandage. The putty is applied around the protrusion of the cochlear implant to distribute the applied splint pressure on the patient's scalp and improve patient tolerance of the applied compression bandage. A typographical error in the practice expense summary of recommendation incorrectly listed SL042 instead of the correct supply code of SL082 for impression material.

### **Telehealth**

CMS received requests to permanently add CPT code 77427 Radiation Treatment Management to the Medicare Telehealth Services List. CPT 77427 was added to the Telehealth List on a temporary basis during the COVID-19 Public Health Emergency (PHE) with provisional status through December 31, 2024.

**AAPM supports the CMS proposal to remove CPT code 77427 Radiation Treatment Management from the Medicare Telehealth List beginning in 2025 and encourages the Agency to finalize this proposal in light of patient safety and quality of care concerns.**

Face-to-face engagement between radiation oncologists, clinical treatment teams, and patients undergoing radiation treatment is the most appropriate way to manage care. The physical examination is an integral part of patients' cancer treatment management during the course of radiation therapy and ensures quality of care. While occasional exceptions and flexibilities may be needed to address rural and underserved communities, AAPM believes that it is important for the radiation oncologist to conduct the face-to-face portion of the weekly management code in-person.

### **MIPS Quality Measures**

In the 2024 MPFS final rule, CMS finalized the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)* quality measure for the CY 2025 Performance Period/2027 MIPS Payment Year and future years.

For 66 years, the AAPM is and has been a leading scientific and professional organization for continual improvements and assurance of the highest quality imaging and dose-image optimization for the safety and benefit of patient care. Based on our broad expertise and deep track record, **the AAPM remains concerned regarding this quality measure as currently developed. In summary, this quality measure lacks national consensus of stakeholders and practitioners and has significant scientific limitations that will impact its safety and practical value.** These limitations will decrease the measure's overall likelihood of clinical impact and may even negatively impact image quality, patient safety, and patient outcomes. Further, this measure would disproportionately burden hospitals serving

a low-income population (e.g., rural and inner-city hospitals) due to their older equipment and lack of in-house physicists.

Given that CMS has paused implementation of the Appropriate Use Criteria for Advanced Diagnostic Imaging, we believe that a quality measure that addresses excessive CT radiation dose is important; however, the science behind this specific proposed quality measure is lacking. **AAPM advocates for the development of national consensus metrics, with input from scientific, manufacturing, and standards stakeholders, towards scientific, meaningful, and practical assessment and tracking of CT dose and image quality.**

### Additional Details

While efforts to enhance consistency of CT practice are noble and include initiatives by AAPM and others nationally and worldwide, this measure has significant limitations that impact its scientific and practical value. These limitations include non-consensus, non-standardized, and gross under-representation of image quality, improper estimation of radiation risk (in terms of dose length product (DLP) adjusted by patient size, not the actual patient dose and explicitly prohibited by the AAPM standard), over-simplified stratification of CT categories, and substantial oversimplified representation of implementation in practice, including not addressing the implementation challenges. We also believe that even attempting to implement this measure would cause excessive burden for medical physics and radiological technologist staff without any clear benefit.

The AAPM strongly agrees that efforts need to be continually placed on ensuring diagnostic quality CT imaging, optimizing CT dose, and achieving consistency across facilities, considering differing technologies and practices. The non-profit entities of the AAPM, the American College of Radiology (ACR), and Image Wisely and Image Gently Alliances have spent decades working towards this goal and continue to do so through many initiatives. Among them, the non-profit ACR CT Dose Index Registry (DIR; <https://www.acr.org/Practice-Management-Quality-Informatics/Registries/Dose-Index-Registry>, established in 2011) has the significant stature of implementing a dose registry that enables facilities to compare dose indices nationally, to ensure the highest quality imaging with lowest possible dose. The ACR CT DIR implementation incorporates the expert, consensus opinions of the medical imaging community.

### Analysis and Concerns

AAPM's significant concerns about this eCQM and its adoption in the 2024 MPFS final rule are based on detailed reviews by leading AAPM experts on this topic, and broad consensus across multiple committees of experts that we have conducted over the past year. This position stems from six major concerns about the proposed measure:

1. *Unscientific characterization of CT scan risk:* The measure is based on risk estimation approaches and their uncertainties that are not reflective of the consensus of the scientific community. At the present time, epidemiological evidence supporting increased cancer incidence or mortality from radiation doses below 100 mSv is inconclusive.<sup>2</sup> Given the lack of scientific consensus about potential risks from low doses of radiation, predictions of hypothetical cancer incidence and mortality from the use of diagnostic imaging are highly speculative. The AAPM, and other radiation protection organizations, specifically discourages these predictions of hypothetical harm.
2. *Inactionability of the measure to enable targeted change to improve practice:* It is not clear how the measure can be practically used to improve imaging practice and how a facility can achieve

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<sup>2</sup> <https://www.aapm.org/org/policies/details.asp?id=2548>

compliance, given the wide variety of factors and technologies involved. For instance, estimation of patient size for CT dose estimation remains an evolving challenge due the wide range of body habitus. In addition, the measure uses size-adjusted DLP to characterize radiation exposure, but there is no established and accepted method for adjusting DLP by patient size.

3. *Inadequate addressing of the complexity of CT categorization:* The measure does not address the magnitude of the complexity of CT categorization (e.g., body, adult, dynamic, etc.) nor does it suggest means to overcome it given that even current standards are lacking in the uniform characterization of protocols. The CT categorization scheme in this measure inadequately addresses criteria such as the reason for the scan, CT reconstruction parameters, and patient size. Inaccurate classification of data can lead to significant errors in the resulting aggregated data, leading to erroneous conclusions negatively impacting patient care.

For example, one reference cited to support the proposed measure has an accompanying editorial highlighting the proposed approach's limitations [Mahesh M. Benchmarking CT Radiation Doses Based on Clinical Indications: Is Subjective Image Quality Enough? *Radiology*. 2022; 302:2, 390-391]. The editorial and stated limitations are not addressed in the eCQM proposal.

4. *Inadequate assessment of noise:* Use of "global noise" can misrepresent the quality of an exam and does not account for the diversity of influences on noise in a CT image, such as differences in CT technologies or new reconstruction methods that may dramatically alter noise. Further, noise does not have a singular value in a CT exam.
5. *Inadequate assessment of image quality:* Image quality is affected by a myriad of factors including resolution and contrast, as well as the intended purpose of the exam. A singular representation of image quality via global noise is a gross simplification of image quality, leading to misrepresentation of image quality that detracts from patient care. By example, a CT image protocol may be purposefully designed that yields higher noise to best address a particular diagnostic imaging task. A recent study by leading CT experts presented at the Radiological Society of North America 2022 annual meeting clearly documents that CT noise is only a tertiary consideration of image quality as judged by leading radiologists (Gress et al. Ranking the Relative Importance of Image Quality Features in CT by Consensus Survey, RSNA 2022 – the refereed paper is currently under review by *Radiology*).
6. *Emphasis on dose reduction instead of dose optimization:* We appreciate inclusion of both radiation dose and image quality as factors in the eCQM as a balance; however, the eCQM incorrectly emphasizes dose reduction, instead of dose *optimization*, for the imaging task at hand. Individualization and optimization of care and safety should be the goal, not dose minimization. Minimizing doses can lead to patients being underexposed, resulting in reduced image quality, potentially missed or delayed diagnosis, and even repeat scans thereby ultimately increasing dose to the patient.

We thank you for this opportunity to submit our comments and request that CMS carefully consider these issues for the final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 631-0677.

Sincerely,



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President, American Association of Physicists in Medicine



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Chair, Professional Economics Committee