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September 10, 2025

Dr. Mehmet Oz
CMS Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–1832-P
7500 Security Boulevard
P.O. Box 8016
Baltimore, MD 21244-8016

Re: 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

Dear Dr. Oz:

The Society for Cardiovascular Angiography and Interventions (SCAI) has dedicated its work to advancing the profession and is the designated society for guidance, representation, professional recognition, education, and research opportunities for invasive and interventional cardiology professionals. For more than 40 years, SCAI has personified professional excellence and innovation globally, fostering a trusted community of more than 5000 members dedicated to medical advancement and lifesaving care for adults and children with cardiovascular disease.

SCAI appreciates the opportunity to comment on this proposed rule. SCAI offers the following comments on:

1. Conversion factor update
2. Indirect Facility PE Cost Allocation
3. Telehealth
4. Efficiency Adjustment
5. Left Atrial Appendage Occlusion
6. Lower Extremity Revascularization

7. High cost supplies
8. Percutaneous Coronary Interventions
9. Software as a Service
10. Chronic Disease RFI
11. Ambulatory Specialty Model
12. MIPS
13. MVP Core Elements RFI
14. Cost Measure Informational Period
15. MVP Selecton Requirements

Conversion Factor Update

SCAI appreciates the update for 2026, however, must note that the 2.5% increase is temporary, and neither .25 or .75 percent keeps up with inflation, especially in light of the years of cuts physicians have taken. SCAI urges CMS to find a way to avoid future decreases and work with Congress to reform the payment system. **We urge CMS to waive the budget neutrality adjustment and encourage CMS to look at all options for avoiding future cuts.**

In a letter sent to CMS in May, the American Medical Association (AMA) noted that, due to overassumptions of usage of the new G2211 code, the MPFS is underfunded by \$1 billion. According to the AMA, in 2024, Medicare began paying for HCPCS code G2211, which was developed to be reported along with office visits when there is a longitudinal relationship between the physician and patient for medical services related to a single, serious or complex condition. Under the Medicare statute, CMS must annually adjust the conversion factor to maintain budget neutrality. An estimate for G2211 spending was needed for the budget neutrality calculation, and in the CY 2024 MPFS final rule, CMS calculated that 38 percent of all office visits reported would be billed with G2211. However, an AMA analysis of the first three quarters of 2024 Medicare claims data found that G2211 was only reported with 10.5 percent of office visits, a dramatic decrease from CMS estimates. **As such, SCAI implores CMS to make a prospective budget neutrality adjustment to the 2026 conversion factor to correct for this overestimation and return the unused funds to the MPFS.**

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

CMS is proposing to reduce the indirect PE cost calculation by 50% from the non-facility calculation. CMS states the reasoning for this proposal is that CMS believes the current calculation overstates the range of indirect costs incurred by facility-based physicians. However, by taking this reduction to all procedures performed in the facility setting, CMS is reducing payment to all physicians that perform any procedures in the facility setting, even those that do maintain an office. This unintended consequence could hurt office-based practices as it will reduce the reimbursement on the procedures that make up the majority of practice revenue. Additionally, physicians that are facility-based often have contracts that require them to lease

back their office space which is not being taken into consideration under this proposal. **SCAI asks CMS to reconsider this proposal and at minimum lower the amount of the proposed reduction to account for these circumstances.**

Changes Related to Telehealth Services

CMS is proposing to move all existing codes on both the provisional and final telehealth list to one approved list for telehealth services. **SCAI appreciates CMS converting the provisional telehealth services to permanent status to ensure access is preserved.**

CMS is proposing to make permanent the temporary provision to allow direct supervision via virtual presence for cardiac rehabilitation programs. SCAI appreciates this proposal and agrees with CMS that this policy should continue in perpetuity. This would allow the direct physician supervision of cardiac rehabilitation programs to be met by the virtual presence of the physician via real-time, two-way audio/visual telecommunications technology.

Physicians are clearly in the best position to determine whether virtual direct supervision can be provided safely and effectively. Physicians understand their patients' medical needs, and should be given the flexibility to make those decisions on a case-by-case basis. **Therefore, SCAI applauds CMS for proposing to allow physicians the ability to make decisions based clinical judgment as to whether a service is appropriate for virtual direct supervision.**

Proposed Efficiency Adjustment

CMS is proposing an efficiency adjustment of 2.5% to be taken on all non-time-based services in the MPFS. This novel adjustment is based on the CMS assumption that most codes have not been revalued in an appropriate timeframe and that the efficiencies of performing procedures over time have not been adequately captured. **SCAI strongly disagrees with this assessment and would urge CMS to not finalize this proposal as written.**

The proposed adjustment is arbitrary and capricious, because it is based on the last five years' productivity adjustment in MEI. Unfortunately, physicians do not receive a positive MEI adjustment, therefore, reducing services by a percentage of an increase they do not receive is highly suspect. Additionally, the proposed across the board reduction does not taking into account that the thousands of procedures being affected are very different procedures with different levels of work efficiency. Such a proposal ignores the time and intensity argument that CMS requires for code valuation. Efficiencies gained in longer surgeries will vary greatly from those gained in shorter diagnostic tests. Such an across the board approach is inappropriate and breaks with years of interpreting statute to require taking individual procedure

characteristics into account. CMS proposes to implement this adjustment every three years, which again is an arbitrary number that assumes that efficiency gains are possible in all procedures time over time. This assumption is unrealistic, as many procedures such as diagnostic tests reach their peak efficiency and barring changes to technology, remain at that level for many years.

Rather than an arbitrary efficiency adjustment applied to nearly all CPT codes, CMS could instead consider ensuring that higher volume codes be reviewed on a more frequent basis. The RUC has a process of screens through their Relative Assessment Workgroup process, which already captures codes with high volume increases and could certainly be adjusted to capture all high volume codes within a 10 year timeframe. This is a realistic measure that could be taken to appropriately account for efficiencies in the codes that amount to the largest amount of Medicare spending, without an arbitrary adjustment. Additionally, other tools could be introduced into the RUC process such as time and registry data as it proves to be readily available. CMS could also supply the RUC with Medicare Advantage data, so a more accurate picture of beneficiary usage could be used in the valuation process. **SCAI urges CMS to work with the AMA RUC to come up with other processes that more accurately ensure efficiencies are captured instead of finalizing this arbitrary adjustment.**

CMS also proposes to implement the efficiency adjustment on all non-time based codes, including those that have been reviewed by the RUC recently, including in this MPFS proposed rule. CMS has had the opportunity to review RUC recommendations and make a determination on how those codes should be valued. As CMS has not accepted RUC values on many of those codes, CMS has had the opportunity to reduce these services for efficiency and including them in this arbitrary adjustment is discriminatory against those that have been recently through the established valuation process. Also, reducing new codes that have only just been surveyed for the first time and not yet billed based on the past five years when the codes did not exist is arbitrary and capricious and should not occur. **SCAI implores CMS not to finalize the proposed efficiency adjustment.**

Left Atrial Appendage Occlusion (LAAO)

For the left atrial appendage occlusion code, CMS is proposing to accept the RUC valuation of 10.25 wRVUs. While SCAI respects the RUC process, in this instance there were extenuating circumstances that SCAI believes makes this value inappropriate. At the time of the survey, the other code sets discussed in this rule, percutaneous coronary interventions and lower extremity revascularization, were in the re-valuation process and therefore unavailable for use as either reference service codes on the survey or crosswalks at the RUC meeting. It was because these

codes were not available that the RUC landed on 49614 hernia as an appropriate crosswalk. The intraservice time for the hernia repair is the same as the survey at 70 minutes, but repairing a hernia does not have the same intensity as a service performed on a beating heart. **For these reasons, SCAI would implore CMS to leave LAAO at its existing value and allow the societies to resurvey for the January 2026 RUC meeting, now that the PCI and LER codes have been valued and can be appropriately used.**

If CMS feels this code must be revalued this cycle, for some undisclosed reason, SCAI would respectfully ask CMS to look at the crosswalk 92941 as more appropriate. It has similar times and the work RVU is less than the current 14.0 established for LAAO. Even if CMS were to take a reduction based strictly on the reduction in time from the survey, the RVU would still come out to 10.89, which is still higher than the crosswalk reached by the RUC. Additionally, SCAI would ask CMS to exclude this code from the proposed efficiency adjustment should any adjustment be finalized. As this code was just revalued and took a substantial cut to both wRVU and time, any efficiencies were captured within the revaluation process.

Lower Extremity Revascularization (LER)

For the lower extremity revascularization code set, CMS is proposing to accept the RUC valuation for all codes. SCAI agrees with CMS' decision. However, SCAI would ask CMS to exclude these codes from the proposed efficiency adjustment should any adjustment be finalized. As these codes were just revalued, any efficiencies would have been captured within the revaluation process. Additionally, this code family includes several new codes which cannot have achieved efficiencies as the codes have yet to be billed and tracked.

For the practice expense, CMS had concerns that the recommendations had inconsistent quantity allocations across different code sets for the number of units for the drug-coated balloon (SD382) and the drug eluting stent, tibial (SD379). We reiterate the RUC's explanation for the apparent discrepancy.

CPT codes 37X10, 37X12, 37X18 and 37X20 would typically require two drug-coated balloons, whereas their corresponding add-on codes (37X11, 37X13, 37X19 and 37X21) would typically only require one drug-coated balloon for each additional vessel. For the base codes, the surgeon is typically treating the superficial femoral artery and popliteal artery, which is considered one segment, and that segment is much longer than the common femoral artery or the profunda femoris. It is typical to have multifocal or long-segment disease in the superficial femoral artery and popliteal artery segment where one drug-coated balloon, which can only be used once, will not be adequate to treat the whole area. It would be most common to report

the add-on codes for the common femoral artery or the profunda femoral artery segment, which are short enough that the surgeon can treat them with one drug-coated balloon.

For CPT codes 37X14, 37X15, 37X22, and 37X23, only one unit was recommended for the initial vessel, as these codes describe femoropopliteal angioplasty or femoropopliteal atherectomy, which would most typically be reported for treatment in the common femoral or profunda femoris segments of the femoropopliteal region, which are much shorter vessels and therefore have shorter disease segments. This does not represent a “discrepancy” but rather the appropriate course of treatment of the typical scenario for the codes.

The tibial segment complex codes 37X33 and 37X34 typically require two drug-eluting stents each, whereas tibial segment straightforward codes 37X31 and 37X32 only require one drug-eluting stent each. The length of the vessel is the same between a straightforward and a complex lesion for 37X31-37X34. The difference is that in tibial interventions, the surgeons are typically working with stents that are 38mm long, which is still relatively short. In general, the surgeon would only use stents where they determine they must maintain the vessel’s patency. For a straightforward lesion, a stent is usually only needed in one location. Whereas for complex lesions (which are defined as occlusive disease), the occlusive disease is typically quite long. It is most typical to use 2 stents in the tibial segment for complex lesions, and there are even edge cases where the surgeon could use 4 or 5 stents in the tibial segment. The longest stents are around 38mm, whereas the tibial segment averages around 250-300mm. Similarly, complex lesion CPT Codes 37X41 and 37X42 require the use of two drug eluting stents for the same reasons.

High Cost Supplies

CMS has requested comments on whether the agency should create G-codes to describe the use of high-cost supplies or use the Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) to accurately price these services. **SCAI firmly believes that supply costs that exceed \$500 should be removed from the physician fee schedule and paid separately.** Current practice expense methodology distorts expenses associated with high cost supplies as it was not intended to cover costs associated with services usually covered under a facility fee. CMS should review options such as using HCPCS codes for these supplies or paying them separately by removing them completely from the fee schedule. While SCAI is not against other options such as OPPS MUC, SCAI has concerns about how such an option would work, as there are distinct differences in the payment systems that would make such a substitution difficult. For example, LER services are assigned to comprehensive APCs in the OPPS, making it challenging to align with MPFS because all ancillary services are bundled into the APC. In

addition, the LER family also includes several add-on codes which complicates any alignment further because add-on codes are not paid separately under OPPS. Any changes of this nature would need to be carefully vetted and reached in a transparent process that includes the relevant medical societies.

Percutaneous Coronary Interventions (PCI)

For the percutaneous coronary intervention code set, CMS is proposing to accept the RUC valuation for all codes. SCAI agrees with CMS' decision. However, SCAI would ask CMS to exclude these codes from the proposed efficiency adjustment should any adjustment be finalized. As these codes were just revalued, any efficiencies were captured within the agreed upon revaluation process. Additionally, this code family includes several new codes which cannot have achieved efficiencies as the codes have yet to be billed and tracked.

Software As A Service

CMS is requesting information on how CMS should consider payment for software as a service. In the cardiology field, the influx of new technology using Artificial Intelligence has been proliferative. Giving every technology its own separate payment is both burdensome and overwhelming. The number of new CPT codes that would exist would make it nearly impossible to maintain the integrity of code families as they would be reopened for valuation at almost every CPT meeting. It is SCAI's opinion that only those technologies with a physician work component should be given a CPT code and that work component should result in generic codes that can be used by multiple technologies across specialties. Payment for any technical component should be paid using HCPCS codes that the technologies receive when going through the facility payment process and must be paid separately from the MPFS. Due to the number of technologies and the size of the payments, adding these additional supply costs to the MPFS will only amplify the issues already being felt with high cost supplies. A separate methodology such as using HCPCS codes or like the chemotherapy model must be used for software technologies.

Request for Information (RFI): Prevention and Management of Chronic Disease

CMS is seeking information on how to enhance their support management for prevention and management of chronic disease. One chronic disease that is lacking in preventative support under the MPFS is peripheral artery disease (PAD). PAD is a serious, life-threatening disease that has a higher mortality rate than most cancers. There is an epidemic of amputation and over 50 percent 4-year mortality with severe disease. PAD prevalence is set to triple in next 30 years while there is a shortage of providers to address the disease through interventions.

PAD frequently goes undetected because many patients don't know about the disease or the signs to look out for. Too many patients, especially in medically underserved communities, only learn they have PAD when they are already facing an amputation. By screening high-risk individuals for PAD, physicians can catch this disease early in its progression and work with patients to protect their health. **SCAI urges CMS to add PAD screening for high risk patients to the Medicare program.**

Ambulatory Specialty Model

CMS is proposing a mandatory Ambulatory Specialty Model to include the diagnoses of heart failure and low back pain. While CMS states that subspecialists will not be included in the model, we have concerns about how their specialty designation will be captured. It is SCAI's belief that many interventional cardiologists are enrolled in the Medicare program under the designation cardiology. Therefore, using this designation to select physicians for participation in the model may inadvertently affect subspecialists that, while they do treat heart failure patients, care of these conditions is not the focus of their practice. These physicians would need an adequate notification period of members being attributed to them to object to the classification within the model and be able to petition for their removal. Even those that do focus on heart failure patients need to be made aware of patient attribution to ensure appropriate participation. **SCAI urges CMS to review the model for physician selection and patient attribution transparency.**

MIPS

CMS is proposing to maintain the performance threshold at 75 points through performance period 2028. SCAI appreciates CMS' willingness to maintain this threshold to add some stability to the MIPS program for the next few years while participants navigate other changes as CMS prepares to transition to MVPs. Additionally, as CMS looks at ways to decrease the burden of MIPS on participants, it is important to note that having more available measures to report in the program is less burdensome than the reduction of such measures. For participants such as subspecialists, finding appropriate measures to report can be difficult. As the number of available measures decreases, the process becomes more burdensome, making it difficult to find measures to report and have any chance of being successful in the program. Allowing participants to choose what measures fit best for their practice is by far the most effective way to encourage participation and decrease burden.

Request for Information (RFI): MIPS Value Pathways (MVPs) Core Elements

CMS is requesting information on whether it would make sense to have a group of core elements within each MVP that would have to be submitted by all practitioners that elect that

MVP. This would allow real comparisons among practitioners reporting on the same MVP. While SCAI understands the desire for accurate comparisons across MIPS MVP participants, we have several concerns about the unintended consequences of such a policy. Even though CMS has increased the number of MVPs made available, there are still several subspecialties, such as interventional cardiology, that are not adequately represented in MVPs. For example, interventional cardiologists reporting the Advancing Heart Care MVP would then be required to report on core measures that are more directed at general cardiologists, putting them at a clear disadvantage for comparison scoring. Additionally, SCAI is unclear if CMS means for the core measures to be reported just among a specific MVP or to be a more generalized reporting layer across all MVPs. Our concerns encompass either option, as the difference in subspecialty becomes even more apparent when trying to find measures that can be reported across the board. **Before such changes are implemented, and before the transition to MVPs, SCAI would implore CMS to ensure that all specialties are adequately served by the MVPs offered.**

Cost Measure Information Period

CMS is proposing to adopt a two-year informational-only feedback period for new MIPS cost measures. SCAI applauds CMS for taking this step to add some transparency to the MIPS process. Cost measures are very difficult for physicians to understand and increasing scores in this category without this understanding is nearly impossible. Being able to review the feedback on a two year cycle will allow MIPS participants to better understand what is expected of them and to be able to provide feedback to CMS of any concerns with how the measure is working before being penalized. SCAI would ask that CMS review if there is a way to implement such transparency with current cost measures, perhaps providing feedback mid-year so that all participants get the same benefit.

Request for Information (RFI): Medicare Procedural Codes

CMS is requesting information on whether CMS should use billing procedure codes to assist CMS with assigning MIPS participants to relevant MVPs. While SCAI appreciates that CMS is looking at ways to assist participants in choosing avenues to successfully participate in MIPS and MVPs, SCAI disagrees with assigning a participant to an MVP based on procedure billing. Not all MVPs are appropriate for all subspecialties that report the same procedures. For example, an interventional cardiologist reports codes for lower extremity revascularization, but so do vascular surgeons and interventional radiologists. Requiring an interventional cardiologist to report on the vascular surgery MVP based on billing these procedures alone would be inappropriate, as the vascular surgery MVP does not widely apply to interventional cardiologists. Similarly, the Advancing Heart Care MVP may currently be the most appropriate MVP for interventional cardiologists to report, but the primary procedures reported by

interventional cardiologists do not indicate that a non-procedure based MVP would be the best fit. **Before such changes are implemented, and before the transition to MVPs, SCAI would implore CMS to ensure that all specialties are adequately served by the MVPs offered.**

Conclusion

SCAI appreciates the opportunity to provide comments on this Proposed Rule for CY 2026 and we look forward to continuing working with CMS to address these important issues. If SCAI can be of any assistance as CMS continues to consider and review these issues, please do not hesitate to contact SCAI's director, regulatory affairs Monica Wright at 202-327-5451 or at mlwright@scai.org if there are any questions or further requests.

Sincerely,

A handwritten signature in black ink, appearing to be 'Srihari S. Naidu', with a long horizontal flourish extending to the right.

Srihari S. Naidu, MD, MSCAI
President