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Society for Cardiovascular Angiography & Interventions

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September 10, 2025

Submitted electronically via: http://www.regulations.gov

Dr. Mehmet Oz
CMS Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–1834-P
7500 Security Boulevard
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

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.

Phase Out of IPO List
CMS is proposing to phase out the IPO list over the course of three years. SCAI believes that the removal of procedures from the IPO list should be a decision primarily focused on whether a particular patient service is reasonable and appropriate in the outpatient setting of care. Care should be taken in this process, leaving more complex procedures on the list until the end of the phase out giving time for those procedures to be properly

vetted. Physicians that perform these procedures should be included in the decision-making process as their experience, expertise and discretion is essential to ensuring that proper care is given to beneficiaries receiving these services.

SCAI agrees with CMS in making these procedures exempt from certain medical review activities until such time as it is certain these procedures are being commonly performed in the outpatient setting. Many of these procedures have never been performed outside of an inpatient setting and it will take time for the site of service change to be implemented. This exemption also allows for procedures that are not deemed safe enough to be performed outpatient to have the ability to provide the appropriate level of patient care.

Even when the change is appropriate, there will be challenges in determining the appropriate outpatient or ambulatory surgery center fees. For procedures rarely or never performed outside of the inpatient setting, it may be appropriate to phase them out later as CMS works to resolve appropriate payment for the setting including any complexity adjustments for adjunct services.

Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services Furnished to Hospital Outpatients

CMS is proposing to make permanent the temporary provision to allow direct supervision via virtual presence or 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 on clinical judgment as to whether a service is appropriate for virtual direct supervision.**

Request for Reassignment of Complexity Adjustment for CPT Code 0523T

CMS made a change in how it applies the complexity adjustment for code 0523T. Currently, it only applies when performed with CPT code 93460 (combined left and right heart catheterizations).However,this adjustment used to also be applied to CPT code 93458 (left heart catheterization with coronary angiography alone).

Left heart catheterization (CPT code 93458) is performed in over 60% of patients, while only about 10% undergo both left and right heart catheterizations (CPT code 93460). CMS' current

proposal restricting the complexity adjustment to 93460, means that reimbursement for 0523T with 93458 is no longer appropriately adjusted for clinical complexity. This change could inadvertently limit beneficiary access to this valuable, evidence-based technology by discouraging its most common use, while potentially encouraging overuse of the clinically unrelated right heart procedure. **SCAI requests that CMS reinstate the complexity adjustment for 0523T when billed with 93458 to ensure appropriate reimbursement.**

Proposed Changes to Payment Rate for all Services within the Diagnostic Tests and Related Services APC Family (APCs 5721-5724)

SCAI is concerned about significant and unexplained payment reductions across the entire Diagnostic Tests and Related Services APC family 5721-5724. These reductions appear to be driven largely by the reassignment of high-volume procedures between APCs, but CMS provides no explanation for the changes in the cost statistics files. **SCAI urges CMS not to finalize these reassignments and asks CMS to clearly identify proposed changes to APC groupings, explain the rationale, and provide the opportunity for public comment before implementing changes in APC assignment.**

ASC Covered Service List

SCAI is committed to quality, efficiency, patient experience and preference regarding treatment options, as well as site of service options. We are also committed to fiscal responsibility and identifying mechanisms that will bring cost-savings to the healthcare system.

We have concerns, however, about the ASC-CPL list additions in Table 80 of this proposed rule. The percutaneous coronary interventions (PCI) on the list are fragmented and random, including several HCPCS C codes without their CPT counterparts and including the most complex procedures while excluding more straightforward cases. For example, C9602 coronary atherectomy with stent is on the list while CPT code 92924 for coronary atherectomy is not. Similarly, the new add-on retrograde CTO CPT code is listed while the antegrade base code 92944 required to bill 92X02 is not. **SCAI believes these inconsistencies are problematic and asks CMS to provide a closer review of the PCI code set**.

SCAI emphasizes the need for physician discretion and good judgment and practice when selecting which cases are appropriate for the ASC setting. Certain lesions carry higher risk and therefore require more caution than others. Often heavility calcified lesions and vein grafts may need a setting with more support, but many lesions identified by the same set of CPT codes would be appropriate in the ASC setting. **SCAI supports the addition of the remainder of the PCI code set 92920 – 92979, 93571, 93572, 93463 to the ASC-CPL list to allow physician discretion on a case-by-case basis.**

It is imperative that patients undergoing PCI in the ASC setting receive the same quality of care

afforded to cardiovascular patients receiving PCI in the hospital outpatient setting. We urge CMS to support the establishment of minimum facility standards that will assure quality of care in the ASC setting including a mandate for participation in a quality assurance and performance improvement process and to track outcomes for percutaneous coronary interventions (PCI) procedures performed in the ASC site of service. We urge CMS to identify a mechanism to directly cover the expense to ASCs to participate in a low-cost, quality registry. We believe this investment in the accrual of data will provide significant savings by aggregating data, enabling benchmarking, and providing a system which promotes process improvement.

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,

Srihari S. Naidu, MD, MSCAI
President

President