CardioVascular Coalition
Joining Together for Patient Access

September 12, 2025
Submitted electronically via: http://www.regulations.gov

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2026 Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

The CardioVascular Coalition (CVC) appreciates the opportunity to offer its comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule for the CY 2026 Physician Fee Schedule (CMS-1832-P).[1] The mission of the CVC is to advance patient access to cardiovascular care, particularly as it relates to peripheral artery disease (PAD) and coronary artery disease (CAD). CVC Members include providers and industry representing physicians and staff in 45 states at over 378 centers where minimally-invasive cardiovascular care services occur.[2]

CVC comments in this letter relate to the following issues:

- New Lower Extremity Revascularization Code Set
- Updates to the Indirect Practice Expense (PE) Methodology
- Use of OPPS data to set PFS rates
- Undervaluation of conversion factor due to G2211 Assumption
- Efficiency Adjustment

I. New Lower Extremity Revascularization Code Set (CPT codes 37XX1, 37X02, 37X03, 37X04, 37X05, 37X06, 37X07, 37X08, 37X09, 37X10, 37X11, 37X12, 37X13, 37X14, 37X15, 37X16, 37X17, 37X18, 37X19, 37X20, 37X21, 37X22, 37X23, 37X24, 37X25, 37X26, 37X27, 37X28, 37X29, 37X30, 37X31, 37X32, 37X33, 37X34, 37X35, 37X36, 37X37, 37X38, 37X39, 37X40, 37X41, 37X42, 37X43, 37X44, 37X45, and 37X46)

The CVC appreciates the comments by CMS regarding the RUC-recommended inputs for the new 46 CPT codes regarding the endovascular revascularization of the lower extremities. The code proposal is the culmination of a multispecialty effort over a period of many years that strove to incorporate new technologies, techniques and standards of care that have been developed over the last decade and a half since the lower extremities codes were last valued. However, the changes made to the inputs by CMS and the associated comments are somewhat puzzling and the CVC would like to address those comments. Overall, we recommend that CMS reconsider its changes

[1] Federal Register, 90 FR 32352, 16 July 2025
[2] For more information about CVC, please see https://www.cardiovascularcoalition.com/about-us

to the RUC recommendations and that CMS accept the recommendations as submitted.

Drug-Coated Balloon (SD382)

Regarding the drug-coated balloon (SD382), CMS stated that the RUC recommendations "show inconsistent quantity allocations across different code sets." The differences in quantity allocations do not represent an inconsistent strategy but rather an accurate depiction of a complex combination of additive or conjunctive treatments. In the CMS comments, it also was stated that "The RUC documentation specifies two units for the initial vessel and one unit for additional vessels in CPT codes 37X10 - 37X13 and 37X18 - 37X21. However, for CPT codes 37X14 - 37X15 and 37X22 - 37X23, only one unit is listed for the initial vessel."

In CPT codes 37X10 - 37X13 which describe Femoropopliteal angioplasty and 37X18 - 37X21 which describe Femoropopliteal atherectomy and angioplasty, two balloons are required due to the length of disease typical in the superficial femoral and popliteal segments. In these CPT codes, no adjunct drug eluting stents or covered stents are being used and therefore the definite therapy is the drug coated balloon. These balloons are used in long segments of arterial disease in the superficial femoral/popliteal portion of the femoropopliteal region and two balloons is typical as a drug coated balloon can only deliver its therapeutic payload upon one area during a single inflation according to the FDA instructions for use (IFU).

For CPT codes CPT codes 37X14 - 37X15 and 37X22 - 37X23, only one unit is listed for the initial vessel as these codes describe femoropopliteal angioplasty or femoropopliteal atherectomy and angioplasty in an add-on vessel. The add-on vessel is most typically going to be used to describe treatment in the common femoral or profunda femoris segments of the femoropopliteal region which are much shorter vessels and therefore have shorter disease segments. Only one drug coated balloon is necessary most typically and therefore only one was included. This does not represent a "discrepancy" but rather the appropriate course of treatment of the typical scenario for the codes.

CMS also listed the discrepancy in the allocation of Drug Coated Balloons related to the absence of these balloons in CPT codes 37X16 and 37X17 (Femoropopliteal Angioplasty and Stent), 37X24 and 37X25 (Femoropopliteal Atherectomy, Angioplasty and Stent) and 37X26 (Femoropopliteal IVL add-on) as support for an inconsistent method of counting the number of required DCBs. As stated in the above, there is a well described methodology for the selection of PE inputs that correlates directly to the expected typical treatment algorithm as determined by the multispecialty expert panel and validated by the RUC process. Description of the rationale for each of these codes was in the submitted SOR. In 37X16, 37X17, 37X24 and 37X25 covered stents were felt to be typically used and therefore the use of DCBs would be unnecessary as the treated segments will be covered by a fabric coated stent. In the CPT code 37X26 the PE inputs are limited to the added work of Intravascular Lithotripsy which is performed in addition to the base codes of the family. Additional DCBs would not be listed in this code as they are already listed in the appropriate base codes if, and only if, they are necessary in the completion of the appropriate course of therapies. The selection of individual inputs and the appropriate limitation of unnecessary inputs was the result of an exhaustive collaborative effort of six specialty societies over a period of a number of years.

REQUEST: We request that CMS reconsider its changes to the RUC recommended PE inputs for CPT codes 37X10, 37X12, 37X18, and 37X20 and restore the number of drug-coated balloon (SD382) to two per code.

Drug Eluting Stent (SD 379)

CMS also commented that there were discrepancies in the number of tibial Drug Eluting Stents (SD379) throughout the code set. The utilization of tibial stents has expanded due to an increase in the availability of advanced techniques, the improvement in the quality and availability of drug eluting stents and the expanding utilization of endovascular procedures in the treatment of limb threatening ischemia. At the time that the Xpert stent was listed as the PE supply input for tibial stenting, it was the only product available with the sizes appropriate for tibial vessels. Since the time that the previous code set was valued, Xpert stents have been removed from the market and are no longer used. It is inappropriate for CMS to use the prior number of supply inputs for a new expanded code set at the expense of the recommendations of numerous treating specialties and the RUC. The CVC agrees that 37X33 and 37X34 (which describe tibial angioplasty and stent placement in complex lesions) typically require the use of two Drug Eluting Stents due to the length of the lesions and the underlying heavy calcification commonly associated with this pathology. The longest available Drug Eluting Stent FDA approved for the use in tibial vessels is 38 mm whereas the typical length of a tibial artery is 250-300mm. Similarly, we agree that 37X41 and 37X42 (which describe tibial atherectomy, angioplasty and stent placement in complex lesions) require the use of two Drug Eluting Stents for the same reasons. It is important to note that these complex codes (37X33, 37X34, 37X41 and 37X42) are felt to represent the minority of tibial interventions and that it will be much more likely for tibial interventions to not require stent placement. Additionally, many more of the treatments will be simple stenoses and if stent placement is performed will only require a single drug eluting stent in most cases.

REQUEST: For the reasons stated above and to appropriately represent the actual administration of these therapies in the Medicare population the CVC requests that CMS reconsider the changes to the RUC-recommended PE inputs and restore the number of supply code SD379 (drug eluting stent, tibial) for four CPT codes in the tibial and peroneal vascular territory, CPT codes 37X33, 37X34, 37X41, and 37X42 to two each.

II. UPDATES TO PRACTICE EXPENSE (PE) METHODOLOGY – SITE OF SERVICE PAYMENT DIFFERENTIAL

Many terms are synonymous with "office-based," including "private practice," "freestanding," "nonfacility," or "place of service 11" and such providers often are independent physicians, small businesses, and rural providers. In the 2026 PFS Proposed Rule, CMS notes strong concern relating to the collapse of private practice, stating:

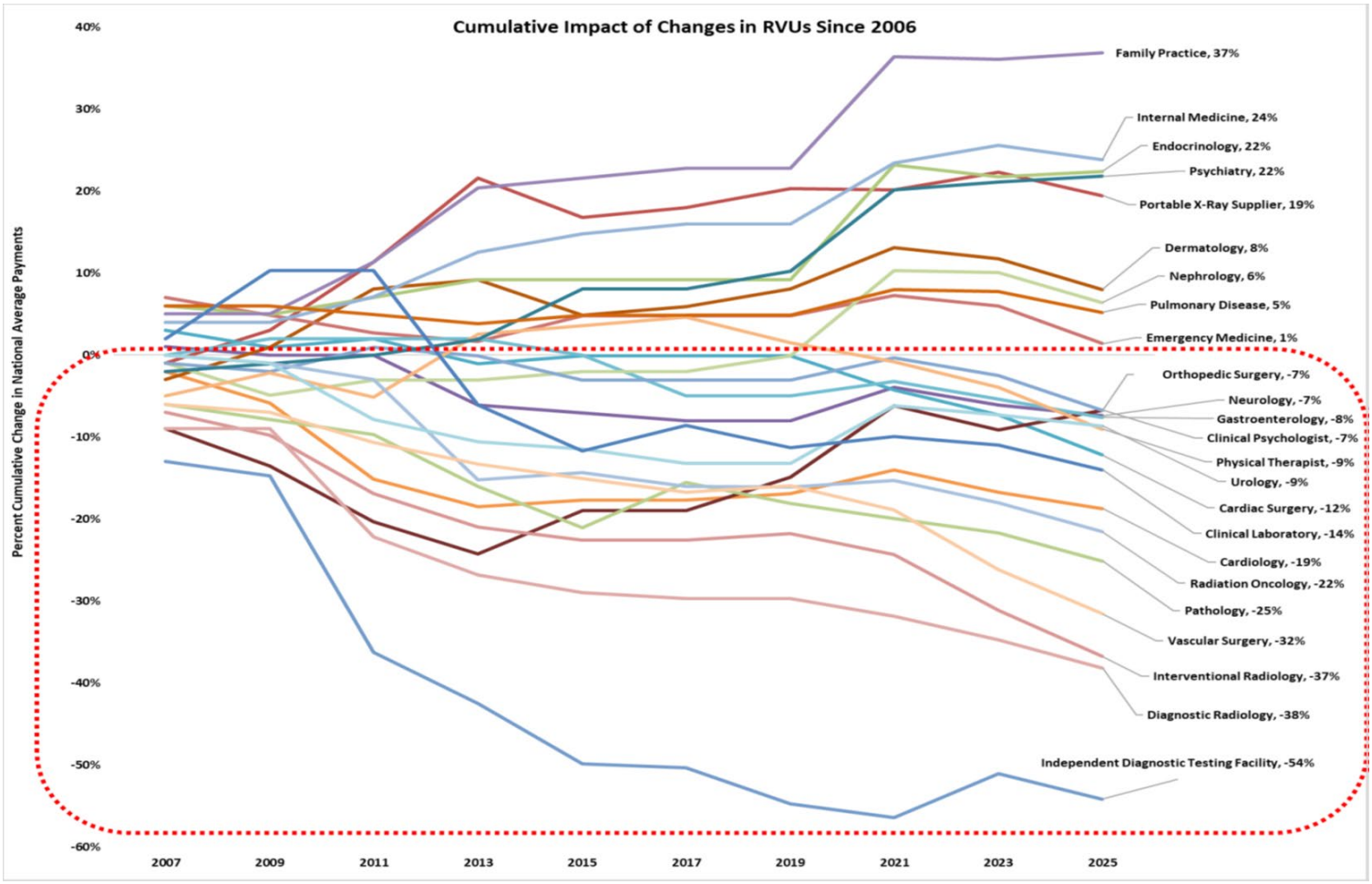
- [T]rends indicate a steady decline in the percentage of physicians working in private practice, with a corresponding rise in physician employment by hospitals; and growth in the percentage of physicians who practice exclusively, or almost exclusively, in the facility setting. When the PFS was established, the methodology for allocating indirect practice expense was based in part on an assumption that the physician maintained an office-based

practice even when also practicing in a facility setting. In that context, the PE methodology has allocated the same amount of indirect costs per work RVU, without regard to setting of care.

- We share MedPAC's concerns regarding the potential for duplicative payment under the current PE methodology for allocating indirect costs for physicians practicing in the facility setting. Allocating the same amount of indirect PE per work RVU for services furnished in the facility setting as the nonfacility setting may no longer reflect contemporary physician practice trends.
- For these reasons, for each service valued in the facility setting under the PFS, we are proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs beginning in CY 2026.

For office-based interventional providers in particular, cuts since 2006 have been upwards of 20 – 40% or more (see Chart I).[3]

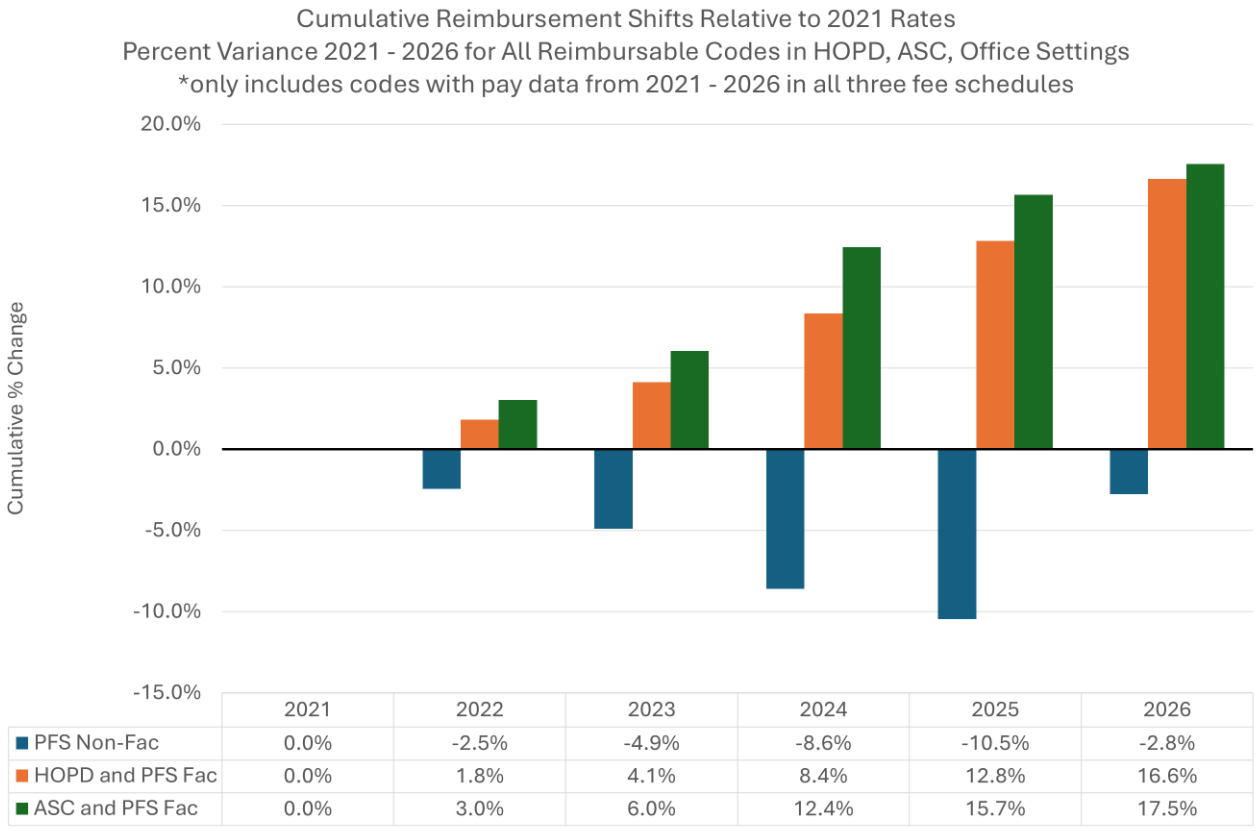
CHART I



[3] HMA analysis 2007-2025 Medicare Physician Fee Schedule Impact Tables.

Fortunately, due in part to the proposed update to the PE methodology, the 2026 PFS Proposed Rule marks the first meaningful improvement for office-based (i.e. non-facility) providers in years. Meanwhile, global HOPD and ASC rates also continue to rise, largely unaffected by the IPE policy.[4][5] To confirm our statements, we analyzed all codes common to HOPD, ASC, and non-facility settings over a 5-year period (see Chart II).[6] Since 2021, global facility rates have never declined year-over-year, while non-facility settings declined each year through 2025. Due to policies in the 2026 PFS Proposed Rule, 2026 finally brings an increase for all three of these settings. Still, over the five-year span, cumulative rate growth is 17.5% for ASCs, 16.6% for HOPDs, and -2.8% for office-based locations.

CHART II



	2021	2022	2023	2024	2025	2026
PFS Non-Fac	0.0%	-2.5%	-4.9%	-8.6%	-10.5%	-2.8%
HOPD and PFS Fac	0.0%	1.8%	4.1%	8.4%	12.8%	16.6%
ASC and PFS Fac	0.0%	3.0%	6.0%	12.4%	15.7%	17.5%

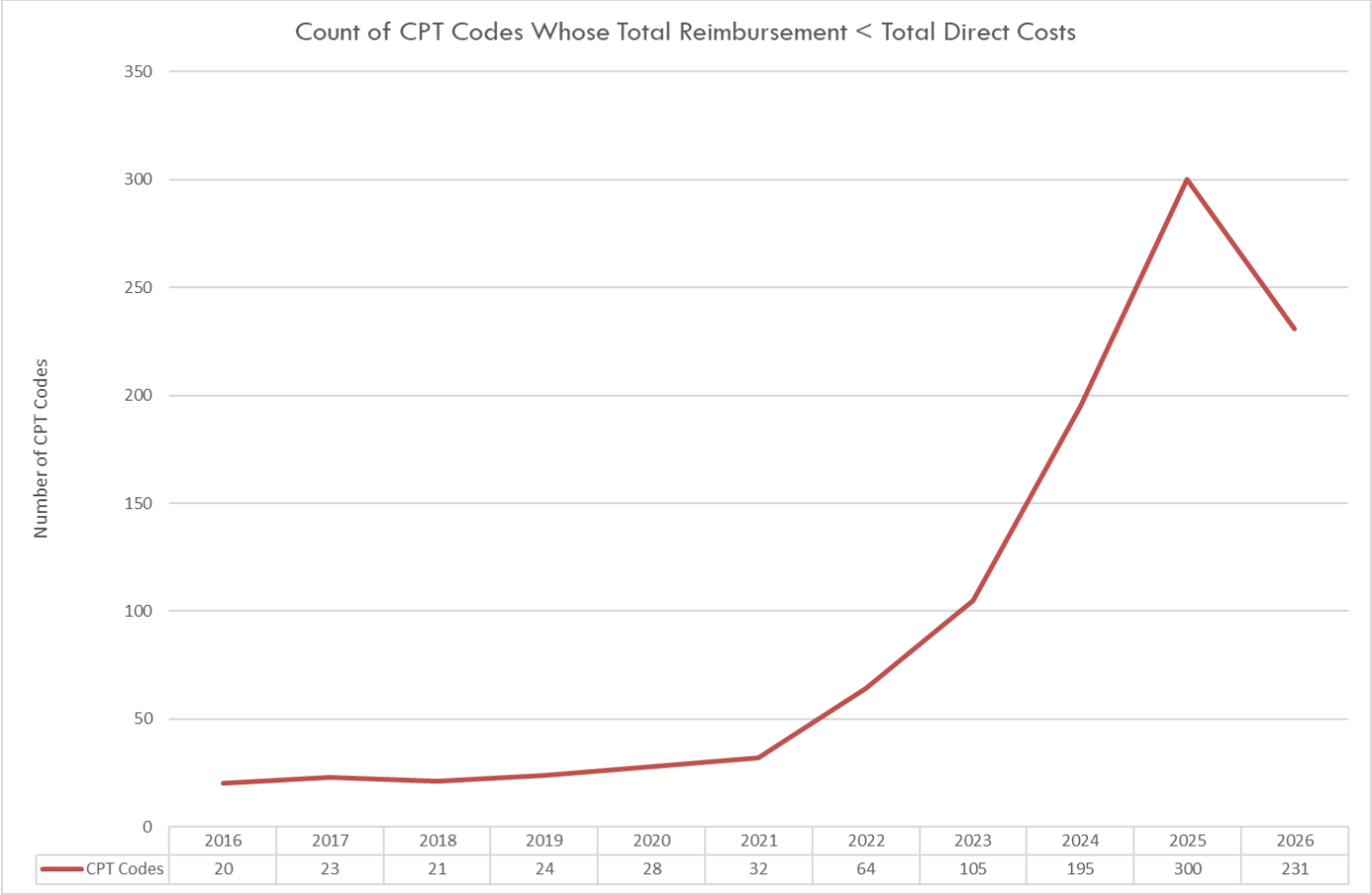
[4] In addition, physician compensation in hospitals tends to include base salary, work RVUs, quality incentives, etc. rather than PFS indirect practice expense. https://sullivancotter.com/wp-content/uploads/2020/11/Infographic-2020-Physician-Compensation-and-Productivity-Survey.pdf

[5] "Global" rates means PFS nonfacility (which includes professional and technical fees) as well as global hospital outpatient fees (hospital outpatient PPS tech + PFS facility) and global ASC fees (ASC PPS tech + PFS facility).

[6] Analysis is based on data from 2021 – 2025 final rules and 2026 proposed rule for the Hospital Outpatient PPS, ASC PPS and Physician Fee Schedules.

Cuts to office-based interventionalists have become so severe that, in 2025, there are 300 procedures across service lines that are paid at rates less than just the direct costs associated with those procedures – as calculated by CMS itself (see Chart III).[7] The 2026 PFS Proposed Rule represents an important step in the right direct to correcting historical cuts to office-based interventional care, but additional actions must be taken to address this problem permanently.

CHART III



Physician Practice Information Survey

CMS rightly emphasizes in the rule that the AMA's Physician Practice Information Survey (PPIS) data is not a reliable benchmark for practice costs. In fact, PPIS has long blended practice expense and hourly rate (PE/HR) data between freestanding and hospital-based settings, which undermines its relevance for office-based reimbursement.[8] The PPIS survey results would have triggered significant year-over-year cuts across office-based specialty interventional services (e.g. 37225 [limb salvage]: - 10.2%, 37243 [fibroid embolization]: -12.6%, 36475 [venous ulcer]: -12.6%, 52441 [urology]: -15.2%, G6015 [radiation therapy]: -17.9, 36902 [dialysis vascular access]: -

[7] Analysis is based on data from 2016 – 2025 final rules and 2026 proposed rule for the Physician Fee Schedule.
[8] The Lewin Group analysis of PPIS data contained in the 2010 PFS Proposed Rule. Download available here: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/lewin_group_analysis_of_radiation_oncology.pdf

20.7%, 64555 [implant neuroelectrodes]: -26.5%).[9]

In contrast, maintaining the current MEI structures in collaboration with the IPE policy is a step toward a more equitable system. Such an approach supports community-based providers, improves access to essential preventive services (especially in rural and underserved regions), and helps reduce long-term costs for CMS. This is a meaningful and long-overdue correction and we commend CMS for taking action to preserve and strengthen community-based care delivery. For the vast majority of office-based specialties, the IPE policy will save their ability to practice independently.

REQUEST: The IPE policy advances patient-centered care, supports market-based solutions, and acknowledges the needs of many private practice, office-based, and independent physicians. CVC supports the CMS proposal to update the IPE policy as a means of providing reimbursement stability that freestanding providers have desperately needed for the years.

III. USE OF OPPS DATA TO SET PFS RATES

In the 2026 PFS Proposed Rule, CMS seeks comments on whether to use Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) and/or APC relative weights to price supplies and equipment for PFS services. For years, the AMA RUC has recommended "CMS separately identify and pay for high-cost disposable supplies priced more than $500."[10] Removing high-tech supply and equipment services from the PFS also could involve new "place of service" designations for such services and more appropriate inclusion in the larger ambulatory technical (i.e. OPPS/ASC) fee schedule. We believe the inclusion of certain high-tech supply and equipment services in the larger ambulatory technical (OPPS/ASC) fee schedule would be the best way for CMS to provide an "evidentiary basis to shape optimal PE data collection and methodological adjustments over time," given previous CMS statements that, "we continue to seek the best broad based, auditable, routinely updated source of information regarding PE costs."[11] Removing high-tech supply and equipment from the PFS also would free up resources within the PFS to achieve its primary raison d'être: reimbursement for physician work.

Reimbursing under the OPPS/ASC fee schedule for certain high-cost technical inputs used in office-based interventional care would stop further closures of independent procedural practices, given that the PFS effectively no longer covers such procedures. Importantly, such a policy also would (1) protect the PFS from further dilution from unsubsidized migration of high-cost equipment and supplies from the hospital and (2) provide additional resources for the overall PFS. Moreover, there is clear precedent for such action: in the 2010 PFS, the Centers for Medicare & Medicaid Services (CMS) finalized its proposal "to remove physician-administered drugs from the definition of physicians' services" due to the "significant and disproportionate impact that the inclusion of drugs has had on the SGR system."[12]

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[9] Berkeley Research Group, Analysis of PPIS survey data impact on the Physician Fee Schedule, March 2025
[10] https://www.ama-assn.org/system/files/oct-2020-ruc-recommendations.pdf
[11] 83 FR 59455
[12] CY 2010 PFS Proposed and Final Rules. 74 FR 33650 and 74 FR 61965

REQUEST: Because the PFS was not built for high-cost supplies and equipment, the CVC supports the use of OPPS data to set rates for services utilizing high-cost equipment and supplies in the PFS, but recommends working with Congress to remove such services from the PFS altogether through mechanisms such as H.R. 10136 (the Promoting Fairness for Medicare Providers Act) and S. 1031 / H.R. 2120 (the ROCR Value Based Program Act).[13]

IV. UNDERVALUATION OF CONVERSION FACTOR DUE TO G2211 ASSUMPTION

In a May 2025 letter to CMS, the AMA noted that, due to faulty assumptions relating to the adoption of the new G2211 code, that the PFS 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, and the physician serves as the continuing focal point for medical services that are part of ongoing care related to a patient's single, serious condition or a complex condition. Under the Medicare statute, CMS must annually adjust the Medicare CF to maintain budget neutrality, meaning that increases in payment for one service must be offset by corresponding decreases elsewhere, so that overall Medicare spending does not rise solely due to changes in relative value units. To determine the budget neutrality adjustment needed for G2211, the Biden Administration needed to develop an estimate of how frequently G2211 would be billed in 2024. The final estimate that CMS included in the CY 2024 MPFS final rule was that G2211 would be billed with 38 percent of all office/outpatient E/M visits reported in 2024. However, instead of being reported with 38 percent of all office visits, an AMA analysis of the first three quarters of 2024 Medicare claims data found that G2211 was reported with only 10.5 percent of office visits.

REQUEST: The CVC supports AMA arguments on G2211 and urges CMS to correct the utilization estimate for G2211 based on actual claims data from 2024 by making a prospective budget neutrality adjustment to the 2026 CF in the 2026 PFS proposed rule.

V. EFFICIENCY ADJUSTMENT

In the 2026 PFS Proposed Rule, CMS proposes applying a 2.5% decrease to the work RVUs and physician intra-service time of most services in the MPFS on the assumption that physicians have gained efficiency in providing them. This includes new services, surveyed for physician time and work within the past year. The decrease would be applied to 8,961 physician services. CMS arrives at a 2.5% efficiency adjustment by tallying the last five years' productivity adjustments in the MEI. However, physicians do not receive an MEI-based update even though other Medicare providers receive a productivity adjustment applied to their annual baseline updates (e.g., hospital market basket minus productivity). This proposal, combined with the AMA/Specialty Society RVS Update Committee's recommendations on individual CPT codes, results in the 0.55% budget neutrality adjustment to the conversion factor.

[13] https://www.cureus.com/articles/282828-the-physician-fee-schedule-was-not-built-for-high-cost-supplies-and-equipment#!/

REQUEST: The CVC does not support any efficiency adjustment policies within the Physician Fee Schedule without a concurrent automatic update to the conversion factor based on MEI.

CONCLUSION

We look forward to continuing to work with CMS to maintain and improve access to minimally-invasive cardiovascular care services while we strive to reduce racial and ethnic disparities in care and amputations overall. If you have additional questions regarding these matters and the views of the CVC, please contact Jason McKitrick at (202) 465-8711 or jmckitrick@libertypartnersgroup.com .


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