ASTCT®
American Society for
Transplantation and Cellular Therapy

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
SUBMITTED ELECTRONICALLY VIA REGULATIONS.GOV

September 13, 2026

RE: Medicare and Medicaid Programs; CY 2027 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 (CMS-1848-P)

Dear Administrator Oz:

The American Society for Transplantation and Cellular Therapy (ASTCT) is a professional membership association of more than 3,900 physicians, investigators, and other health care professionals. Our mission is to advance stem cell transplantation (SCT) and cellular therapies through groundbreaking research, high-quality education, impactful advocacy, and clinical excellence. ASTCT's comments in relation to the CY 2027 Medicare Phyisican Fee Schedule (MPFS) proposed rule continue to reflect our focus on making innovative therapies available to all Medicare beneficiaries who need them.

ASTCT thanks CMS for the opportunity to provide comments on the proposed rule. We are ready to discuss any aspect of our comments further with your staff.

Regards,

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ASTCT President
2026-2027

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Executive Summary

ASTCT appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the CY 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule. The following is a summary of our principal comments and recommendations.

1. Conversion Factor and Cumulative Payment Changes
ASTCT is concerned about the cumulative effect of annual payment changes, statutory budget neutrality requirements, and rising practice costs on physician practices and beneficiary access to highly specialized care. ASTCT urges Congress and CMS, within their respective authorities, to pursue a more stable and sustainable approach to MPFS updates that reflects increases in the costs of furnishing care and reduces the disruptive effects of budget neutrality adjustments.

2. Physician Work Efficiency Adjustment
ASTCT continues to oppose application of the efficiency adjustment to physician work and urges CMS not to impose an additional round of reductions when the adjustment is next recalculated. Any future changes to physician work should be based on evidence regarding the resources required to furnish particular services rather than a broad economy-wide productivity assumption. Newly released codes, including CPT code 38228 for CAR-T administration, should be exempted from the adjustment.

3. Practice Expense (PE) Methodology
ASTCT recognizes the complexity of CMS' proposed changes to the PE methodology and supports efforts to improve the accuracy and stability of PE payments. ASTCT supports the concept of recognizing both physician work and clinical labor in the Step 8 indirect PE allocator and supports the phase-out of the Indirect Practice Cost Index in concept, while urging CMS to monitor specialty- and code-level redistributive effects and provide greater transparency regarding the independent impact of the proposed changes. ASTCT also supports a stabilization adjustment to limit abrupt year-to-year PE changes. However, ASTCT recommends that CMS repeal the 50 percent reduction in indirect PE for services furnished in the facility setting and not impose further reductions without reliable evidence regarding the actual indirect costs borne by physicians and practices.

4. E/M Visit Complexity Add-On Code G2211
ASTCT supports continued recognition of the additional resources involved when a physician or other qualified health care professional serves as the continuing focal point for care or provides ongoing care for a patient with a single serious or complex condition. If CMS replaces G2211 with the proposed percentage-based MOD1 modifier, CMS should ensure that the change does not diminish recognition of these resources and should clearly explain and monitor its payment and distributional effects across E/M visit levels and specialties.

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5. Accounting for Overlap Between Stand-Alone E/M Visits and Global Periods
ASTCT recommends that CMS not finalize the proposed 50 percent reduction in payment for separately identifiable E/M services furnished on the same day as a global procedure. CMS has not demonstrated the amount of residual resource overlap, if any, or established that a uniform 50 percent reduction accurately reflects duplicated resources across the affected services. ASTCT also does not support expanding the policy to additional E/M services or settings.

6. Medicare Telehealth Services
ASTCT supports continued access to Medicare telehealth services when clinically appropriate, including the proposed implementation of statutory extensions of key Medicare telehealth flexibilities through December 31, 2027. Telehealth is particularly valuable for transplantation and cellular therapy patients who may travel substantial distances for specialized care. ASTCT supports maintaining flexibility for clinicians to determine the appropriate modality based on the needs and circumstances of the individual patient.

7. Physician-Patient Counseling Regarding Clinical Trial Participation
ASTCT supports appropriate recognition of substantial physician and qualified health professional work associated with counseling patients regarding clinical trial participation. Before establishing a new HCPCS G-code, however, CMS should consider whether clinically necessary counseling can be appropriately reported through the existing E/M code set. If CMS needs additional data to identify these services, ASTCT recommends considering a modifier rather than creating a separate G-code. Medicare payment should recognize clinically necessary counseling while remaining clearly distinct from costs appropriately borne by clinical trial sponsors or research funding.

8. Advance Care Planning
ASTCT recognizes the importance of advance care planning for patients considering or undergoing stem cell transplantation and cellular therapy. If CMS establishes HCPCS codes GACP1 and GACP2 for advance care planning furnished by clinical staff, CMS should clearly distinguish the clinical staff work reported through those codes from practitioner work reported through CPT codes 99497 and 99498, including when both the practitioner and clinical staff participate during the same encounter.

9. Remote Physiologic and Remote Therapeutic Monitoring
ASTCT supports appropriate safeguards to ensure that remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services are medically necessary, appropriately ordered and supervised, and furnished to the beneficiary. However, ASTCT does not support a categorical prohibition on contracted third-party support and recommends targeted oversight and accountability measures instead. ASTCT also recommends that CMS retain the existing CPT coding structure for RPM and RTM rather than replacing those codes with Medicare-specific G-codes.

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10. Current Procedural Terminology and RUC Request for Information
ASTCT supports maintaining CPT as the single national nomenclature for reporting physician and other professional services. No alternative identified by CMS is currently positioned to replace CPT without substantial disruption. ASTCT supports continued improvements in transparency, participation, and evidence while emphasizing that meaningful participation by practicing clinicians is essential to both code development and valuation. Medical necessity determinations should remain distinct from code development, and CMS should not replace CPT with another terminology or broad payment-grouping system absent a clearly superior, fully developed alternative.

Conversion Factor and Cumulative Payment Changes

ASTCT recognizes that the CY 2027 proposed rule contains a number of significant changes to MPFS payment methodology. CMS estimates a combined 0 percent impact for hematology/oncology from the work, practice expense, and malpractice relative value unit (RVU) changes reflected in its specialty impact table; however, that estimate does not include the effect of the CY 2027 conversion factor. The Association for Clinical Oncology (ASCO) estimates that, after accounting for the proposed conversion factor and the policy and coding changes in the proposed rule, hematology/oncology reimbursement would decrease approximately 1.5 percent overall in CY 2027. The effect on individual clinicians will vary based on service mix, geographic location, and Alternative Payment Model (APM) participation. Reimbursement stability and a predictable payment system are particularly important in transplantation and cellular therapy, where care is highly specialized, multidisciplinary, and resource intensive. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Table D-B5; Association for Clinical Oncology, “1.5% Reimbursement Cut for Medicare Physician Services Proposed for 2027,” July 14, 2026.

ASTCT also remains concerned about the cumulative effect of annual payment changes, statutory budget neutrality requirements, and rising practice costs on the sustainability of physician practices and beneficiary access to highly specialized care. The proposed CY 2027 conversion factors are $33.1693 for qualifying participants in Advanced

APMs and $32.8409 for non-qualifying participants, decreases of 1.19 percent and 1.68 percent, respectively, from CY 2026. These reductions reflect, among other factors, expiration of the temporary 2.5 percent CY 2026 payment increase. ASTCT urges Congress and CMS, within their respective authorities, to pursue a more stable and sustainable approach to MPFS updates that reflects increases in the costs of furnishing care and reduces the disruptive effects of budget neutrality adjustments.

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Physician Work Efficiency Adjustment

Continued Application of the Efficiency Adjustment

CMS is not proposing a new efficiency adjustment policy for CY 2027. Nevertheless, ASTCT remains concerned about the efficiency adjustment finalized for CY 2026, which reduces intra-service physician time by 2.5 percent for non-time-based services and is scheduled to be recalculated every three years. ASTCT does not believe that broad assumptions about efficiency gains provide an adequate basis for reducing physician work across diverse services. The intensity, complexity, and clinical judgment required to furnish a service do not necessarily decline simply because productivity in the broader economy increases.

We repeat our comment from last year that cell and gene therapies are a prime example of services that can become increasingly complex as they become more common. While ASTCT's clinicians have been providing these since 2017, the class is still evolving. CMS cannot assume an experiential efficiency simply because clinicians have treated more patients. In fact, ASTCT clinicians reported that the more patients they see in the stem cell transplant and cell and gene space, the more diverse and complex these patients are. Treating cancer patients and others who might be candidates for cell and gene therapies is truly new; clinicians are still learning about the cell and gene therapies and how to treat these diseases.

ASTCT therefore continues to oppose application of the efficiency adjustment to physician work and urges CMS not to impose an additional round of reductions when the adjustment is next recalculated for CY 2029 rulemaking. Any future change to physician work should be based on evidence regarding the resources required to furnish the particular services at issue rather than a broad economy-wide productivity assumption. Additionally, we repeat last year's recommendation that newly released codes (those within the last five years, at least) such as Current Procedural Terminology (CPT) code 38228 for CAR-T administration, should be exempted.

Practice Expense (PE) Methodology

For CY 2027, CMS proposes several significant changes to the methodology it uses to allocate PE among services and specialties. ASTCT recognizes the technical complexity of these proposals and the fact that CMS is not adding resources to the PE pool, but rather proposing changes to how this fixed pool of PE RVUs would be distributed. As a result, some services and specialties will see gains while others will see losses even where the actual resources required to care for patients remain unchanged.

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These changes, as noted below, are of particular concern to ASTCT because transplantation and cellular therapy are highly specialized intensive services, primarily provided in hospitals requiring significant clinical time and resources. CMS already pays less indirect PE for services performed in facilities based on an assumption that some practice costs are borne by the hospital. This assumption on CMS' part may not reflect how our programs actually operate.

Therefore, ASTCT requests that CMS ensure any new formulas reflect real practice costs, show specialties what the changes will ultimately do to their services, phase in large reductions rather than impose them abruptly, repeal the 50 percent reduction in indirect practice expense for services furnished in the facility setting, and refrain from further reductions absent reliable evidence regarding the actual indirect costs borne by physicians and practices. We describe these issues in detail below.

Step 8 Indirect Practice Expense Allocator

CMS proposes to revise Step 8 of the practice expense (PE) methodology so that indirect PE is allocated using the sum of work relative value units (RVUs) and the clinical labor portion of direct PE RVUs for many services. ASTCT supports the concept of recognizing both physician work and clinical labor when allocating indirect PE. The proposal may better recognize services for which significant clinical labor resources are necessary to furnish care.

ASTCT urges CMS to monitor the effects of this change carefully and to make code-level and specialty-level impacts transparent. Changes to the allocator redistribute a fixed pool of PE RVUs and can create material effects even when aggregate specialty estimates appear modest. CMS should provide sufficient information for specialties to understand the independent effect of the Step 8 change apart from other simultaneous PE methodology changes.

Phase-Out of the Indirect Practice Cost Index

CMS proposes to phase out the Indirect Practice Cost Index (IPCI) over two years, with half of the measured variation applied in CY 2027 and the IPCI eliminated from the methodology in CY 2028. ASTCT supports reducing reliance on outdated specialty-specific PE per hour data and supports the phase-out in concept. At the same time, the transition can adversely affect specialties whose current IPCI is greater than 1.0, including hematology/oncology. CMS should carefully monitor these redistributive effects and ensure that the transition does not create unintended payment instability for specialties caring for medically complex beneficiaries. Centers for Medicare & Medicaid Services, CY 2027 Physician Fee Schedule Proposed Rule, Practice Expense methodology discussion.

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Practice Expense Stabilization Adjustment

ASTCT supports the concept of a stabilization adjustment that generally limits annual code-level PE RVU changes to plus or minus 5 percent. A stabilizer can reduce abrupt year-to-year changes while CMS transitions to a substantially revised PE methodology. ASTCT recommends that CMS provide clear information regarding the fully implemented PE values, the expected transition path for affected services, and the continuing application of the stabilizer after the IPCI is fully phased out. Predictability is essential for practices planning staffing, infrastructure, and other investments necessary to provide complex specialty care.

Site of Service Payment Differential

ASTCT remains concerned about the policy CMS implemented for CY 2026 that allocates only half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared with the non-facility setting. The 50 percent amount was not supported by evidence demonstrating that physicians furnishing services in facilities incur only half the indirect costs associated with non-facility services. CMS itself acknowledges in the CY 2027 proposed rule that employment arrangements and actual indirect costs vary and is seeking additional information regarding these costs.

This issue is particularly relevant to transplantation and cellular therapy, which are frequently furnished in hospital-based and highly integrated care environments. A facility site of service does not mean that all physician practice expenses disappear. Professional practices may continue to incur costs associated with coding, billing, scheduling, compliance, information technology, administrative support, and other functions necessary to furnish and report physician services.

ASTCT therefore recommends that CMS repeal the 50 percent adjustment implemented for CY 2026. Further, we do not support CMS proceeding with any further reductions to the facility indirect PE allocation until it has reliable data demonstrating the costs actually borne by physicians and practices.

CMS' own guidance to hospitals (detailed in Part 1 of the Provider Reimbursement Manual) makes clear that physician administrative costs are excluded from what hospitals can report as allowable hospital costs in the cost report. Specifically, Section 2110.4 of the cost report instructions precludes hospitals from including professional billing costs as allowable costs. This does not mean those costs are not reported in the cost report, just that the dollars do not flow into the data that CMS uses for rate-setting. Given this, the only way for the hospital to recoup costs incurred for facility-based physicians is through MPFS payment.

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ASTCT understands that CMS is seeking input on the possible implementation of a new HCPCS modifier to identify physicians based on employment status. ASTCT has concerns about this given physician employment and contractual arrangements are varied and can change across settings and services. A modifier would add administrative burden and may not reliably identify whether particular practice expenses are borne by a physician practice, hospital, health system, or another entity. If CMS continues to examine this issue, the analysis should focus on the costs associated with furnishing the specific MPFS service rather than relying on a broad employment label.

E/M Visit Complexity Add-On Code G2211

CMS proposes to replace separate payment for HCPCS code G2211 with a new modifier, MOD1, that would be reported under the same circumstances as G2211. Rather than a flat add-on payment, MOD1 would increase payment for the associated office/outpatient Evaluation and Management (E/M) visit by 16 percent. ASTCT supports continued recognition of the additional resources involved when a physician or other qualified health care professional serves as the continuing focal point for care or provides ongoing care for a patient with a single serious or complex condition. This concept is directly relevant to many patients undergoing SCT and cellular therapy, who require longitudinal management of highly complex conditions.

ASTCT recommends that CMS ensure that replacing G2211 with a percentage-based modifier does not diminish recognition of the resources associated with longitudinal management of serious and complex conditions. CMS should clearly explain the payment and distributional effects of the change across E/M visit levels and should monitor whether the transition creates unintended effects for specialties that appropriately use G2211 in caring for medically complex patients.

Accounting for Overlap Between Stand-Alone E/M Visits and Global Periods

CMS proposes to reduce payment when a separately identifiable office/outpatient E/M service is furnished by the same physician or group practice on the same day as a 0-, 10-, or 90-day global procedure. Specifically, CMS proposes to pay 100 percent of the most expensive service and 50 percent of other services. The proposal would apply even when the E/M service is appropriately reported with Modifier 25.

ASTCT recognizes that the estimated aggregate impact of this proposal on transplantation and cellular therapy is small; however, the limited financial impact on a particular specialty does not establish that the proposed valuation methodology is appropriate.

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ASTCT is concerned that CMS has not demonstrated the amount of residual resource overlap, if any, that remains after the existing valuation of the E/M service and procedure. CMS also has not provided a basis for concluding that 50 percent accurately represents any such overlap across the wide range of services to which the policy would apply. A uniform 50 percent reduction should not be adopted without evidence showing both that duplicative resources remain and that the amount of the reduction reasonably reflects those resources.

ASTCT therefore recommends that CMS not finalize the proposed 50 percent reduction. ASTCT also does not support expanding the policy to additional E/M services or settings. Any future proposal should be supported by service-level evidence identifying the specific resources that CMS believes are duplicated and explaining how the amount of any proposed reduction was determined.

Medicare Telehealth Services

Continued Telehealth Flexibility

ASTCT supports continued access to Medicare telehealth services when telehealth is clinically appropriate. CMS proposes to implement statutory extensions of key Medicare telehealth flexibilities through December 31, 2027, including continued flexibility regarding geographic and originating-site requirements and eligible practitioners. CMS also proposes to add several services to the Medicare Telehealth Services List.

Telehealth can be particularly valuable for transplantation and cellular therapy patients who may travel substantial distances to specialized centers and who require ongoing follow-up with highly specialized clinicians. At the same time, telehealth should complement rather than replace in-person care when physical examination, testing, treatment, or the patient's clinical condition requires an in-person encounter. ASTCT supports maintaining flexibility for clinicians to determine the appropriate modality based on the needs and circumstances of the individual patient, with appropriate safeguards for quality, privacy, and patient safety.

Physician-Patient Counseling Regarding Clinical Trial Participation

CMS is seeking comment on whether to establish a new HCPCS G-code to recognize physician or other qualified health care professional counseling of patients who are considering or participating in clinical trials. CMS describes a potential service involving at least 20 minutes of discussion regarding trial eligibility, available options, and the potential risks and benefits of enrollment. ASTCT supports the concept of recognizing substantial physician and qualified health professional work associated with clinical trial counseling. This work is highly relevant in

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transplantation and cellular therapy, where clinical trials are an important pathway for evaluating new cellular, gene, and immune-based therapies.

ASTCT urges CMS first to consider whether a new G-code is necessary to recognize this work or whether clinically necessary counseling regarding clinical trial participation can be appropriately reported through the existing E/M code set. To the extent existing E/M codes appropriately recognize these services, ASTCT recommends that CMS retain the existing coding framework and provide clear guidance regarding when and how physicians and other qualified health care professionals may report this work. This approach would avoid the additional administrative complexity associated with establishing and implementing another HCPCS G-code. ASTCT recognizes that CMS may also be interested in identifying and tracking the frequency with which physicians counsel Medicare beneficiaries regarding clinical trial participation. If CMS determines that additional data are needed for this purpose, ASTCT recommends considering whether a modifier appended to an otherwise appropriately reported E/M service could provide the necessary information without creating a separate G-code.

If CMS nevertheless proceeds with establishing a new G-code, ASTCT recommends that CMS clearly define the circumstances in which the service may be reported and how it interacts with existing E/M services and research funding. Medicare payment should not replace costs that are appropriately the responsibility of a clinical trial sponsor or otherwise included in research funding. At the same time, physicians may furnish clinically necessary counseling and shared decision-making regarding trial participation that is separate from activities undertaken to conduct the research, is not paid by the sponsor, and may not be fully recognized under existing coding. CMS should clearly distinguish these circumstances so that Medicare appropriately recognizes clinically necessary physician work without shifting research costs to the Medicare program.

Advance Care Planning

CMS proposes to establish HCPCS codes GACP1 and GACP2 for advance care planning services furnished by clinical staff under the direct supervision of the billing physician or other practitioner. Under the proposal, existing CPT codes 99497 and 99498 would be used to report time personally spent by the billing practitioner, while the new G-codes would recognize clinical staff time. CMS also proposes to add GACP1 and GACP2 to the Medicare Telehealth Services List.

Advance care planning can be particularly important for patients considering or undergoing SCT and cellular therapy because treatment decisions may involve substantial risks, prolonged treatment courses, and complex patient and caregiver preferences. ASTCT recommends that CMS clearly distinguish the clinical staff work reported through GACP1 and GACP2 from the practitioner work reported through CPT codes 99497 and 99498, including clear guidance

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regarding how the services may be reported when both the practitioner and clinical staff participate in advance care planning during the same encounter.

Remote Physiologic and Remote Therapeutic Monitoring

CMS proposes several refinements to remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM): extending the established-patient requirement to RTM; requiring a separately reportable initiating visit furnished by the billing practitioner before RPM or RTM begins; permitting only clinical staff who are direct employees of the billing practitioner or practice to furnish these services, thereby prohibiting the use of contracted third-party companies; and consolidating the current family of RPM and RTM codes into four new HCPCS G-codes describing set-up and monthly monitoring and management.

ASTCT values RPM and RTM as important tools for patients following a stem cell transplant or cellular therapy administration, especially for managing symptoms and monitoring for complications in a population that is frequently immunocompromised and medically fragile. As ASTCT explained in its CY 2026 MPFS comment letter, ASTCT members are increasingly establishing post-treatment remote monitoring protocols—including continuous tracking of vital signs and assessment of neurocognitive function—to support patients recovering from transplant and cellular therapy. ASTCT recognizes the program-integrity concerns identified by the Department of Health and Human Services' Office of Inspector General (OIG) and supports appropriate safeguards to ensure that RPM and RTM services are medically necessary, appropriately ordered and supervised, and furnished to the beneficiary.

ASTCT is however concerned that prohibiting the use of contracted third-party support goes beyond the enhanced oversight the OIG identified and risks unnecessarily restricting legitimate models of care. The appropriate response to concerns about vendor involvement is stronger oversight and accountability rather than a categorical exclusion of vendors from RPM and RTM arrangements. Stem cell transplantation and cellular therapy programs are frequently based in hospitals and integrated health systems, and some may rely on vendor support for the technology infrastructure and operational capabilities needed to extend monitoring to patients outside the hospital while preserving clinical oversight and accountability by the treating care team. CMS should instead establish safeguards that hold the billing practitioner and treating provider accountable for appropriate clinical oversight of vendor-supported services—for example, through targeted claims edits, modifiers, or other reporting mechanisms that identify third-party arrangements and facilitate focused program-integrity review—rather than prohibiting these arrangements altogether.

Finally, ASTCT does not support replacing the existing RPM and RTM CPT codes with new Medicare G-codes. CMS should retain the existing CPT codes and rely on additional oversight and program-integrity safeguards to address inappropriate utilization. To the extent CMS

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believes changes to the existing descriptors would improve the code set, ASTCT encourages CMS to work through the established CPT process rather than creating duplicative Medicare-specific G-codes, which increase administrative complexity, especially in cases where commercial and Medicaid payers are unwilling to recognize them.

ASTCT recommends that CMS (1) replace the proposed categorical prohibition on third-party support with targeted oversight and accountability measures; and (2) retain the existing CPT coding structure for RPM and RTM rather than adopting the proposed G-codes.

Current Procedural Terminology and RUC Request for Information

Maintain a Single National Coding Nomenclature

CMS seeks comment on the role of Current Procedural Terminology (CPT), potential alternatives to CPT, and the CPT and AMA/Specialty Society RVS Update Committee (RUC) processes. ASTCT supports maintaining a single national nomenclature for reporting physician and other professional services. A common coding system provides consistency across Medicare, Medicaid, commercial payers, clinicians, hospitals, researchers, and other participants in the health care system. No alternative identified in the request for information is currently positioned to replace CPT without substantial disruption.

ASTCT recognizes that no coding and valuation process is perfect and supports continued efforts to improve transparency, participation, and the evidence available to CMS. However, replacing CPT would require development of a comprehensive alternative, transition of payer and provider systems, education, testing, and extensive operational changes. CMS should not undertake such a transition without a clearly superior and fully developed alternative.

Medical Necessity Is Distinct from Code Development

CPT codes describe medical services and procedures; they do not determine whether a service is medically necessary for a particular patient. Medical necessity is determined through applicable coverage requirements and the clinical circumstances of the individual patient. Incorporating medical necessity determinations into the code development process would conflate two distinct functions and could make a national coding nomenclature less useful across different payers and patient populations.

Practicing Clinician Participation Is Essential

The development and valuation of physician services require meaningful participation by practicing clinicians with direct knowledge of the services under review. Determining whether services are clinically distinct and whether they meet the clinical criteria for a Category I code or

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are more appropriately identified through the Category III pathway requires meaningful input from practicing physicians with direct knowledge of the services and their clinical application. Similarly, evaluating physician work and direct practice expenses requires clinical and operational knowledge that cannot be supplied solely by economists, policymakers, or automated tools.

The existing CPT and RUC processes provide structured opportunities for participation by a broad range of specialties and other interested parties. ASTCT supports continued improvements in transparency and accessibility while recognizing that confidentiality may be appropriate in limited circumstances, including where CMS requirements or market-sensitive information are involved. Any alternative process should preserve meaningful practicing-clinician involvement and should not create participation barriers that favor only organizations with substantial financial resources.

Alternatives Identified by CMS Are Not Substitutes for CPT

ICD-10-PCS and other classification systems serve different purposes and are not substitutes for CPT reporting of physician services, despite the fact that ICD-10-PCS was created to classify all procedures. Without a rigorous review of ICD-10-PCS, we cannot say whether the granularity or structure needed to report the full range of hospital and professional services can occur. Similarly, terminology systems such as SNOMED CT support clinical documentation and interoperability but are not designed as comprehensive physician payment coding systems. Therefore, ASTCT does not believe a change to either ICD-10-PCS or SNOMED CT should occur at this time.

ASTCT also does not support grouping physician services into broad payment categories modeled on Medicare Severity Diagnosis Related Groups or Ambulatory Payment Classifications as a replacement for CPT. Physician services vary in work, time, intensity, and practice expense, and broad bundling could obscure clinically meaningful differences among services. Any consideration of alternative coding or grouping approaches should first demonstrate that the alternative improves accuracy without compromising clinical specificity, innovation, or the ability to recognize new services.

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