



American Society of Echocardiography

September 11, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1832-P; Medicare Program; CY 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2025)

Dear Administrator Oz:

On behalf of the American Society of Echocardiography (ASE), the Society for Cardiovascular Ultrasound Professionals™, we thank you for the opportunity to comment on the CY 2026 Medicare Physician Fee Schedule (MPFS) proposed rule (CMS-1832-P). ASE is the largest global organization for cardiovascular ultrasound imaging serving more than 20,000 physicians, sonographers, nurses, veterinarians, and scientists and as such is the leader and advocate, setting practice standards and guidelines for the field. Since 1975, the Society has been committed to advancing cardiovascular ultrasound to improve lives.

ASE supports CMS's ongoing efforts to maintain a sustainable, equitable payment system and to promote high-quality, patient-centered care. However, we have significant concerns about several payment policy changes that will directly impact echocardiography services and patient access, including:

- The continued downward adjustment to the Medicare conversion factor.
- The proposed -2.5% efficiency adjustment to work RVUs for non-time-based services;
- Revisions to the practice expense (PE) methodology for facility-based services;
- Changes to HCPCS code G2211; and

We also wish to provide comments on two forward-looking policy areas:

- Telemedicine expansion for CY 2026; and
- Comment Solicitation on Payment Policy for Software as a Service (SaaS)

Conversion Factor Updates

For the first time in five years, CMS is proposing an increase to the Medicare conversion factor (CF) for CY 2026. As required by statute, two CFs are proposed:

Year	Standard CF (2025)	CY 2026 Non-Qualifying APM CF	CY 2026 Qualifying APM CF
2025	\$32.3465	N/A	N/A
2026	N/A	\$33.4209	\$33.5875

Most ASE members currently receive payments under the non-qualifying Advanced Alternative Payment Models (APMs), which provide lower conversion factors. Unfortunately, there are no qualifying APMs relevant to echocardiography, preventing them from earning higher reimbursement rates and incentive payments. This gap reflects the unique challenges facing echocardiography practices. ASE supports creating APM opportunities specifically for echocardiographers, as these models would enable our members to deliver high-quality, cost-efficient cardiac imaging while focusing on patient care rather than administrative tasks. As such, while the proposed increase is welcome, it will be modest in practice for ASE clinicians and its impact will be significantly diminished by the proposed -2.5% efficiency adjustment, which will erode much of the intended benefit.

ASE acknowledges and appreciates that, for the first time in five years, the CF is moving in a positive direction. However, these incremental gains do not address the structural instability of the Medicare payment system or the cumulative effects of year-over-year cuts to noninvasive cardiovascular imaging. While ASE supported the conversion factor increase in the One Big Beautiful Bill Act (H.R. 1), we remain concerned about having to turn to Congress every year for temporary fixes instead of achieving a permanent, sustainable solution to Medicare payment instability.

ASE calls upon Congress and CMS to create predictability and stability in physician payments by implementing an annual inflation adjustment to the conversion factor based on the Medicare Economic Index (MEI). Unlike other Medicare payment systems, the current Physician Fee Schedule lacks predictable inflationary updates, creating an unsustainable environment for echocardiographers and specialists treating complex Medicare patients as practice costs continue to rise. CMS itself recognized MEI in the final CY 2024 Physician Fee Schedule as "the best measure available" for the three payment components - work, practice expense, and malpractice. Implementing this MEI-based adjustment would allow practices to keep pace with healthcare costs, ease downward pressure on reimbursements, and ensure continued patient access to high-quality cardiac imaging services.

While ASE is appreciative of the conversion factor increase, the benefit is diminished by:

- The absence of qualifying APM pathways that reflect the clinical realities of echocardiography and would allow access to the higher CF; and
- The proposed efficiency adjustment, which will directly offset much of the increase and create uncertainty in long-term payment planning.

Without broader reforms, particularly the creation of viable APMs for cardiovascular imaging and the removal of blunt, across-the-board reductions, Medicare payment policy will continue to threaten the financial sustainability of echocardiography services, especially in rural and underserved communities where these diagnostics are often the only advanced cardiac imaging available.

Efficiency Adjustment for Non–Time-Based Services

The proposed across-the-board 2.5% reduction in work RVUs for non–time-based services fundamentally mischaracterizes so-called “efficiency gains” and rests on a flawed premise. By presuming that all services achieve comparable time and resource savings, without providing any specialty-specific evidence, CMS applies a blanket cut that disregards recent RUC valuations, contemporary practice standards, and the rigorous quality and operational requirements that already govern echocardiography.

CMS has stated that their rationale is that many of these services have not undergone review in over 25 years, which is inaccurate for echocardiography. ASE’s core codes have been reviewed and revalued through the AMA RUC process within the past 6 to 10 years. These valuations already incorporate modern clinical practice, technological advancements, and updated workflow efficiencies. Applying an additional “efficiency adjustment” is therefore duplicative, unsupported, and inconsistent with the principle of maintaining relativity in the Physician Fee Schedule.

Echocardiography services are also governed by rigorous accreditation standards established by the Intersocietal Accreditation Commission (IAC), which are updated regularly to reflect evolving best practices. These standards require facilities to maintain current, fully functional imaging equipment; employ appropriately credentialed sonographers and interpreting physicians; adhere to evidence-based imaging protocols; and implement comprehensive quality assurance programs. Compliance is verified through a three-year reaccreditation process that reviews imaging protocols, staff qualifications, quality measures, and equipment standards. Facilities must also document ongoing staff competency and submit quality metrics to maintain accreditation.

This three-year reaccreditation cycle is highly relevant because it mirrors the interval CMS has proposed for its arbitrary efficiency adjustment. Unlike a blunt, across-the-board cut, the IAC process is a rigorous, evidence-based mechanism that ensures echocardiography services are continually updated, standardized, and optimized for both efficiency and quality. Combined with regular RUC revaluation, echocardiography already undergoes robust, specialty-specific processes that incorporate efficiency into valuation.

Applying a uniform efficiency factor ignores these safeguards, revalues services outside of the well-established AMA RUC process, and undermines the specialty expertise essential to determining appropriate work values. CMS risks distorting relativity across the fee schedule, eroding payment accuracy, and destabilizing access to vital cardiovascular services.

The rationale behind the proposed cut is flawed for several reasons:

- Technological advances do not equate to reduced professional work – While echocardiography technology has improved image quality, reduced artifact, and enhanced diagnostic capabilities, these advances have not reduced the physician’s cognitive workload. In many cases, higher-resolution images require even more nuanced interpretation and integration into complex clinical decision-making.
- No specialty-specific evidence has been provided – CMS has not presented empirical data such as time-motion studies, specialty-specific surveys, or claims analyses to substantiate a 2.5% efficiency gain in echocardiography. Applying a one-size-fits-all adjustment ignores significant variability in complexity, workflow, and patient population.
- Bypassing the RUC undermines the valuation process – The AMA RUC process is a transparent, data-driven methodology incorporating specialty expertise, validated clinical

vignettes, and survey results. Overriding this process with an across-the-board reduction circumvents the mechanisms designed to ensure fair, accurate, and evidence-based valuations.

Recommendations:

ASE strongly urges CMS to withdraw the proposed efficiency adjustment for CY 2026 and instead:

1. Identify and target only those codes that have not undergone review in more than a decade;
2. Use the established RUC process to reassess those services; and
3. Incorporate specialty-specific, empirically validated data and established quality standards (such as IAC accreditation requirements) into any future methodology for evaluating efficiencies.

This targeted, evidence-based approach would preserve valuation integrity, maintain relativity, and ensure that echocardiography, which is already subject to recent review and continuous quality oversight, is not unfairly penalized by a blunt, unsupported payment reduction.

Additionally, ASE urges CMS to formally recognize echocardiography as an advanced imaging modality. Echocardiography is subject to rigorous accreditation standards established by the Intersocietal Accreditation Commission (IAC), which mandate the use of current, fully functional imaging technology, appropriately credentialed sonographers and interpreting physicians, adherence to evidence-based imaging protocols, and comprehensive quality assurance programs. Facilities must undergo reaccreditation every three years, ensuring continuous evaluation, modernization, and alignment with best practices. Beyond these structural safeguards, echocardiography requires specialized physician expertise to integrate imaging findings into complex clinical decision-making for conditions such as valvular heart disease, cardiomyopathies, and congenital heart disease. Its reliance on sophisticated equipment, specialized training, and mandatory accreditation processes places echocardiography squarely within the framework of advanced imaging. Formal recognition in this category would appropriately reflect its clinical intensity, resource requirements, and indispensable role in delivering high-quality cardiovascular care.

Practice Expense Methodology Changes

CMS's proposed revisions to the practice expense (PE) methodology, which include changes to indirect cost allocation formulas and adjustments to clinical labor valuation, would impose unsustainable payment reductions on echocardiography services furnished in hospital outpatient departments. These cuts fail to address the root causes of existing disparities, do not accurately reflect the resources practices incur in facility settings, and would place significant financial strain on physicians and other health care professionals. Left uncorrected, this approach risks accelerating consolidation, undermining independent practices, and reducing access to advanced cardiovascular imaging.

To achieve its stated goal of strengthening private practice, CMS must base policy changes on the most current and comprehensive data available. While we appreciate CMS's acknowledgment that private practices need greater support to remain viable and competitive with hospitals and health systems, the proposed approach falls short. A core driver of this inequity is the structural imbalance whereby hospitals receive automatic, annual inflationary updates, while physician services under the PFS do not. Until this disparity is corrected, layering redistributive cuts onto physician practices will only widen the gap, accelerate consolidation, and destabilize community-based care.

In addition, the proposed reduction to indirect practice expense inputs is arbitrary, lacks empirical support, and does not reflect the real-world overhead borne by physicians providing services in facility settings. Physicians and their practices continue to incur substantial administrative and infrastructure costs including staffing, scheduling, billing, compliance, and quality reporting; even when services are performed in hospitals or outpatient departments. Applying a flat 50% reduction without data or validation ignores these realities and risks distorting payment accuracy across specialties.

While ASE supports updating PE inputs to ensure accuracy, the proposed methodology introduces several fundamental problems:

- Failure to capture the true resource intensity of echocardiography – Echocardiography requires highly skilled sonographers, advanced ultrasound systems, IT and PACS infrastructure, and ongoing investment in training, equipment upgrades, and quality assurance. The proposed model does not adequately account for these recurring costs, which are essential to deliver safe, high-quality imaging.
- Disproportionate impact on diagnostic imaging – The proposal shifts relative PE resources away from imaging toward cognitive services, distorting reimbursement in ways unrelated to actual resource use and undervaluing imaging's vital role in diagnosis and disease management.
- Risks to community and safety-net hospitals – Many hospitals, particularly rural and safety-net facilities, operate on thin margins. Cuts of this magnitude could force service cutbacks, delay technology upgrades, reduce quality initiatives, and compromise timely cardiovascular care.
- Insufficient modeling and transparency – CMS has not provided adequate specialty-level analyses, making it impossible to fully evaluate downstream effects. Echocardiography's resource profile is distinct from other services, underscoring the need for detailed, specialty and modality-specific modeling before finalizing any changes.

Recommendations:

ASE strongly recommends that CMS:

1. Withdraw the arbitrary 50% reduction to indirect practice expense inputs and replace it with a data-driven methodology that reflects real-world overhead;
2. Delay implementation of the revised PE methodology until comprehensive, specialty-specific modeling is completed, publicly shared, and open for comment;
3. Validate that the methodology accurately reflects actual resource use for echocardiography and other imaging services;
4. Provide stakeholders, including ASE, a meaningful opportunity to review and refine the approach; and
5. Consideration of a permanent inflationary update to the Medicare Physician Fee Schedule based on the Medicare Economic Index (MEI), ensuring payments keep pace with real-world practice costs and reducing reliance on redistributive adjustments.

A transparent, data-driven approach that reflects the true costs of delivering care is essential to ensuring PE methodology revisions achieve their intended purpose. By working collaboratively with specialties, CMS can avoid destabilizing practices, prevent inequities across specialties, and create a sustainable, accurate payment framework. Incorporating an MEI-based update is equally critical, as it would correct the structural imbalance between hospital and physician payments, provide stability for practices facing rising labor and technology costs, and ensure fairness across the system.

E/M Visits: Complexity Add-on Code (HCPCS G2211)

CMS proposes to allow HCPCS code G2211 to be billed as an add-on code with home or residence evaluation and management (E/M) visits (CPT codes 99341–99345, 99347–99350). While echocardiography providers utilize G2211 in appropriate clinical scenarios, this expansion raises significant concerns about further conversion factor suppression affecting all physician services.

Echocardiography providers actively use G2211 when providing comprehensive care for patients with chronic cardiovascular conditions, including:

- Same-day E/M and imaging services using Modifier -25;
- Guideline-directed care for patients requiring regular monitoring (e.g., severe aortic insufficiency) where both an echocardiogram and clinical visit occur on the same day; and
- Chronic management of complex cardiovascular patients requiring ongoing longitudinal care.

These scenarios appropriately reflect the complex, longitudinal patient relationships G2211 was designed to recognize.

The proposed expansion threatens to compound existing problems with G2211's budget neutrality effects. CMS projected 38% utilization for office/outpatient E/M visits in CY 2024, but actual data suggest only 11% utilization. According to the AMA, this overestimate drove a budget neutrality adjustment exceeding 2% and continues to suppress MPFS spending by nearly \$1 billion annually, directly impacting all physician services including echocardiography. Expanding G2211 to home/residence settings risks further inflating utilization projections, triggering additional budget neutrality adjustments that would permanently reduce the conversion factor for all PFS services.

Recommendations:

ASE strongly recommends that CMS:

1. Immediately correct the G2211 overestimate by adjusting the conversion factor in the CY 2026 final rule to account for the \$1 billion annual suppression; and
2. Provide transparent, conservative utilization assumptions for the proposed home/residence expansion.

Without these corrections, echocardiography providers face continued reimbursement challenges that threaten both appropriate G2211 utilization for complex cardiovascular patients and overall payment adequacy for diagnostic services.

Telemedicine Expansion

ASE supports CMS's continued expansion of telehealth and remote service flexibilities, including the proposal to extend many of the temporary provisions first introduced during the COVID-19 Public Health Emergency. These policies have demonstrated clear value in maintaining continuity of care, expanding access to specialty expertise, and improving patient outcomes; particularly in rural facilities, critical access hospitals, and underserved communities.

Remote interpretation of echocardiographic studies by qualified physicians has been standard practice for decades, allowing timely review regardless of location and reducing diagnostic delays. ASE wants to ensure that current telehealth policy changes do not inadvertently create barriers to these well-established practices. When telehealth services meet the same clinical standards, documentation requirements, and professional work as in-person care, reimbursement should be equivalent. This parity is essential to support the substantial infrastructure investments, quality assurance processes, and security requirements necessary for high-quality telehealth delivery. Additionally, specialty medical societies bring essential clinical expertise to telehealth policy design, providing critical input on quality

measures, technology requirements, clinical workflows, and best practices to ensure that telehealth policies enhance rather than compromise patient care.

For example, specialized fetal echocardiography demonstrates how telehealth can address unique clinical challenges. Pregnant women often face barriers that prevent travel to specialized pediatric cardiology centers, including distance, transportation challenges, financial limitations, and medical complications such as rupture of membranes or preterm labor that make travel unsafe. In these situations, patients can receive fetal echocardiographic imaging from qualified pediatric sonographers at regional facilities, with remote consultation provided by pediatric cardiologists in credentialed labs with specialized expertise in cardio-obstetrics. This approach eliminates the need for high-risk patients to travel hundreds of miles to specialized centers while ensuring access to expert interpretation and consultation.

Recommendations:

ASE strongly recommends that CMS:

- Continue working with Congress to make permanent the telehealth flexibilities that have proven effective: This includes maintaining the expanded list of covered services, removing geographic restrictions, and allowing the patient's home as an originating site for appropriate telehealth-delivered services.
- Ensure payment parity for telehealth services that meet the same clinical standards as in-person care: When clinical quality, documentation, and professional work are equivalent, reimbursement should be identical. This parity is essential to support the infrastructure investments, quality assurance processes, and security requirements necessary for high-quality telehealth delivery.
- Continue stakeholder engagement in future telehealth policy design: Specialty societies such as ASE can provide valuable input on quality measures, technology requirements, and best practices to ensure that telehealth implementation enhances patient care.

A permanent, equitable telehealth policy framework will strengthen the integration of advanced cardiovascular imaging expertise into diverse care settings, improving timely access to high-quality echocardiographic services while supporting CMS's broader goals of equity, prevention, and cost-effective care delivery.

Software as a Service

ASE appreciates CMS's inclusion of an AI payment Request for Information (RFI). We agree with CMS's acknowledgment that manufacturer-supplied cost data may not reflect true market pricing and fails to capture the full scope of clinical and operational considerations. This underscores the critical need for a comprehensive, evidence-based methodology for valuing AI-enabled diagnostic tools.

AI in echocardiography presents significant opportunities to enhance workflow efficiency, standardize image acquisition and measurement, and promote consistent interpretation. However, as detailed in our RFI responses, AI must function as an enhancement tool that requires physician oversight, not as a replacement for clinical expertise. The physician's role in interpreting AI outputs, validating recommendations, and synthesizing these findings with patient history and clinical presentation remains central to accurate diagnosis and effective care. Current payment models incorrectly assume AI reduces physician workload when these technologies actually introduce new responsibilities for interpretation, oversight, and patient communication.

Recommendations:

ASE strongly recommends that CMS:

- **Foundation Requirements:** ASE recommends that CMS implement a comprehensive framework built on three foundational requirements
 1. **FDA Validation:** CMS must require rigorous FDA validation before any reimbursement consideration. No AI technology should receive payment authorization without completing FDA engagement and demonstrating safety and effectiveness through proper regulatory review.
 2. **Standardized Classification:** CMS should adopt the AMA's CPT taxonomy for AI classification (assistive, augmentative, and autonomous). This framework provides essential structure for determining appropriate payment methodologies and prevents inconsistent coverage policies.
 3. **Physician-Centered Payment Design:** All payment structures must preserve physician centrality in clinical decision-making. AI technologies must enhance, never replace, the clinical judgment and patient-centered decision-making that specialists provide.
- **Technology-Specific Payment Pathways:** Rather than having a one-size-fits-all approach, CMS should establish distinct payment methodologies for each AI category. Assistive technologies for workflow efficiency should operate outside traditional CPT/RUC reimbursement, while augmentative and autonomous technologies require appropriate compensation for the clinical oversight and integration work they demand.
- **Comprehensive Evaluation Framework:** CMS should develop standardized data collection processes that incorporate real-world cost and utilization data, require specialty society and clinician input in the valuation process, require continuous post-implementation monitoring, and resolve liability distribution concerns that currently create barriers to AI adoption.
- **Liability:** Successful AI adoption requires resolving liability frameworks that place disproportionate malpractice risk on clinicians. ASE supports equitable liability distribution across AI developers, healthcare institutions, and regulatory agencies.

Finally, Clinical SaaS represents core infrastructure for echocardiography, enabling image lifecycle management, AI quality tools, interoperability, and cybersecurity. However, it is not a discrete physician service appropriate for MPFS RVUs. Forcing payment through the MPFS misclassifies ongoing software and hosting costs as professional work, triggers budget-neutrality cuts, and distorts pricing. ASE urges CMS to create a separate payment pathway outside MPFS budget-neutrality constraints for qualified clinical SaaS, while preserving professional echocardiography services under the MPFS. This approach maintains pricing accuracy, sustains innovation, and protects appropriate physician compensation.

ASE stands ready to collaborate with CMS in developing this transparent, clinically grounded framework that safeguards physician expertise, reflects actual resource utilization, and supports innovation while maintaining quality care standards.

Final Recommendations

In all, ASE urges CMS to:

1. **Stabilize the conversion factor (CF)** – Work in concert with Congress to enact long-term reforms that prevent continued erosion of the CF, mitigate budget neutrality pressures, and

ensure predictable, sustainable reimbursement for high-value services such as echocardiography.

2. **Withdraw the proposed efficiency adjustment for CY 2026** – Eliminate the across-the-board 2.5% reduction in work RVUs for non–time-based services, as it is unsupported by specialty-specific evidence, disregards recent RUC reviews, and undermines established valuation processes.
3. **Delay implementation of the revised practice expense methodology** – Postpone adoption until comprehensive, specialty-specific impact modeling is completed, publicly shared, and validated through stakeholder engagement to ensure the methodology accurately reflects the true resource use of echocardiography and other services.
4. **Correct the G2211 utilization overestimate** – Restore the conversion factor in CY 2026 to address the \$1 billion annual payment suppression affecting echocardiography and all physician services, and to use conservative projections for any home/residence expansion to prevent further permanent rate reductions.
5. **Make permanent proven telehealth flexibilities with payment parity** – Codify telehealth provisions that have demonstrated clear clinical and operational benefit, maintain payment parity for services meeting the same quality standards as in-person care, and preserve access for rural and underserved communities.
6. **Develop a transparent, evidence-based framework for valuing AI-enabled services** – In collaboration with specialty societies and practicing clinicians, establish a standardized methodology for AI valuation that captures its role in augmenting (not replacing) physician expertise, incorporates real-world cost and utilization data, and links reimbursement to demonstrable quality and outcome improvements.

Conclusion

Echocardiography is indispensable to the timely diagnosis, risk stratification, and management of cardiovascular disease, directly advancing CMS’s goals of preventive, high-quality, and cost-effective care. Payment policies that do not accurately reflect the clinical complexity, resource requirements, and professional expertise involved in these services risk destabilizing service delivery and reducing their value to patients and the Medicare program.

ASE remains committed to working in partnership with CMS to ensure that payment policy changes are evidence-based, equitable, and aligned with the needs of Medicare beneficiaries. We appreciate the opportunity to provide feedback on the CY 2026 MPFS proposed rule and look forward to continued collaboration. If you have any questions on the Society’s comments or if we may provide any additional information, please contact Katherine Stark, ASE Director of Advocacy, at kstark@asecho.org.

Sincerely



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