

December 15, 2009

Submitted electronically

Charlene M. Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1413-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2010; Final Rule

Dear Ms. Frizzera:

The American College of Radiology (ACR), representing more than 37,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, is pleased to submit comments on the final rule with comment period, “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for Calendar Year 2010” published in the Federal Register on November 25, 2009.¹ We will address the following issues: the equipment utilization rate; equipment utilization calculation error; the Physician Practice Information Survey (PPIS); potentially misvalued services under the physician fee schedule; revised bundled codes for 2010 and missing practice expense inputs for select 2010 codes.

The ACR is deeply concerned about the Centers for Medicare and Medicaid Services’ (CMS) decisions on the final rule and the effects they will have on radiology practices beginning in January 2010. CMS must ensure appropriate payment rates and maintain relativity so that these life-saving services can be provided to patients. We urge CMS not to implement the new payment rates for radiology services in 2010 and freeze reimbursement for these services at 2009 levels until appropriate equipment utilization assumptions and survey data can be incorporated into the agency’s rate-setting methodology.

Equipment Utilization Rate

As part of the practice expense (PE) methodology associated with the allocation of equipment costs for calculating PE Relative Value Units (RVUs), CMS adopted an equipment usage assumption of 50 percent. For CY 2010, CMS proposed to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage

¹ 74 Fed. Reg. 61738 (Nov. 25, 2009).

rate for all equipment priced over \$1 million. In the final rule, CMS revised its policy in response to comments opposed to the application of the 90 percent assumption to equipment used in therapeutic services (e.g., radiation therapy and interventional radiology).² We support and appreciate this change from the proposed rule but we remain strongly opposed to the equipment usage assumption of 90 percent for MRI and CT equipment priced at more than \$1 million. For the reasons that follow, ACR believes that CMS' decision to employ a 90 percent equipment utilization assumption for MRI and CT equipment was arbitrary.

CMS cites the March 2009 Medicare Payment Advisory Commission (MedPAC) Report to Congress and the American Medical Association's (AMA) PPIS as the basis for its decision to increase the equipment utilization assumption to 90 percent.³

We note that neither CMS nor MedPAC has collected any additional information on equipment utilization since the 2006 MedPAC survey by the National Opinion Research Center (NORC) of imaging providers in six markets, which found that MRI and CT machines are used more than 25 hours per week.⁴ At the time it was initially presented, MedPAC commissioners were highly critical of the study stating that "the survey was not nationally representative,"⁵ and it was not designed to determine equipment use rates."⁶ However, MedPAC agreed that this was a first step toward establishing a more accurate utilization rate assumption for diagnostic imaging equipment but that a valid survey should be undertaken. In the minutes of the April 19, 2006 MedPAC meeting, it was acknowledged that the MedPAC study on the equipment use rate cannot be considered valid as it included data from only six urban markets rather than a representative national sampling. We also note that this same information was considered and rejected by CMS in the CY 2008 physician fee schedule (PFS) proposed rule.⁷ In that proposed rule, CMS stated, "Although we acknowledge the across the board 50 percent usage rate we currently apply for all equipment does not capture the actual usage rates for all equipment, we do not believe that we have sufficient empirical evidence to justify an alternative proposal on this issue."

We believe CMS was correct in 2008 and see no justification for making a change in the assumption in 2010. In the CY 2010 final rule, CMS states that the AMA submitted summary equipment utilization data from the PPIS on MRI, CT, angiography, intensity-modulated radiation therapy (IMRT) and gamma camera. We reviewed the AMA comment letter and no data are provided. Furthermore, these data have never been made available to the public, making it impossible for us to determine their accuracy, validity

² 74 Fed. Reg. at 61754.

³ Id.

⁴ Medicare Payment Advisory Commission. 2006. Report to the Congress: Increasing the Value of Medicare. Washington, DC: MedPAC.

⁵ MedPAC, Report to the Congress: Medicare Payment Policy, March 2009, at 108.

⁶ Transcript of MedPAC Meeting, Statement of Nancy Ray, April 19, 2006, at 237.

⁷ 72 FR 38122, 38132 (July 12, 2007).

or reliability. We do note that in its comments, the AMA actually stated:

“The AMA conducted a survey of equipment utilization, and although there was a relatively small sample size, the survey responses suggest that equipment utilization varies depending on the type of equipment involved. Therefore, we urge CMS to provide an opportunity for specialty societies to provide data supporting lower utilization rates, if appropriate.”⁸

We believe CMS has mischaracterized the AMA position and has inappropriately relied on data that the AMA indicates came from a relatively small sample size.

In the final rule, CMS dismissed the equipment utilization data presented by the Radiology Business Management Association (RBMA) that showed the utilization rates were closer to 50 percent in actual radiology practice. The ACR, as well as other organizations, believe these data are more representative of equipment usage and better represent actual radiology practice than the less robust MedPAC and PPIS data. The ACR continues to believe that changing the equipment utilization assumption to 90 percent is inconsistent with the requirements of the Balanced Budget Act of 1997 (BBA) which directed CMS to use “actual data on equipment utilization and other key assumptions.”⁹ The ACR urges CMS to examine additional data that we will present in cooperation with RBMA and other organizations and adopt a more appropriate level of equipment utilization for radiology equipment in 2010.

Equipment Cost Calculation

In our review of the direct costs for equipment, we found that CMS changed another assumption about the use of MRI and CT equipment priced at more than \$1 million. This change was not discussed in the proposed or final rules and therefore must represent an error in data entry. Specifically, the data indicate that CMS assumes the MRI and CT equipment is in use 52 weeks a year. This is a change from the assumption of 50 weeks per year that has been in place since the PE RVUs became resource-based in 1999. The effect is an inappropriate additional cut in the direct costs of MRI and CT procedures, leading to incorrect PE RVUs.

The ACR requests an immediate correction of this error. In the event that CMS considers taking the position that this is not an error, we ask that the data on which the change was based be made available. We have carefully reviewed the MedPAC reports and find no discussion of this issue. Further, we would question the PPIS data if it found any practices that are in operation 50 hours per week for 52 weeks per year since such a finding is completely inconsistent with the reality of clinical practice.

⁸ Letter from M. Maves, AMA, to C. Frizzera, CMS, regarding the Medicare Physician Fee Schedule, August 31, 2009, available at <http://www.ama-assn.org/ama1/pub/upload/mm/399/physician-fee-proposed-rule-comment-letter.pdf>.

⁹ Pub. L. No. 105-33, § 4505(d)(1)(A) (1997).

Physician Practice Information Survey

Currently, CMS uses practice expense per hour (PE/HR) data largely obtained from the AMA's Socioeconomic Monitoring Surveys (SMS) from 1995–1999. For radiology, radiation oncology and several other specialties, CMS incorporated PE/HR data that were collected through subsequent supplemental surveys, which were also offered to all specialties and Primary Care Physicians (PCPs). CMS uses these data in lieu of the SMS data to calculate PE RVUs.

The ACR submitted supplemental survey data prior to the original March 1, 2004 deadline established by CMS. As discussed by CMS in the 2006 proposed rule, the ACR's data met the CMS criteria for supplemental surveys, including a high response rate and a high level of precision. The survey was accepted by CMS and, with modifications at various points in time, has been used in the calculation of the PE RVUs since 2007.

The AMA recently concluded a new survey called the PPIS, which was expanded (relative to the SMS) to include nonphysician practitioners (NPPs) paid under the PFS. The PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs using a survey instrument and methods described by CMS in the proposed rule for CY 2010 as “consistent with those used for the SMS and the supplemental surveys.” As described in more detail below, this is an inaccurate characterization of the PPIS, which was conducted at the physician level, not at the practice level as was done for the radiology supplemental survey.

The PPIS, administered in CY 2007 and CY 2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs. The AMA and the CMS contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and nonphysician specialties, respectively.

The current PE/HR for radiology based on the supplemental survey accepted by CMS in 2006, with modifications at various points in time, is \$204.86. According to the PPIS, the PE/HR for radiology **dropped 34 percent** to \$134.84. In our comments on the 2010 proposed rule, we strongly objected to the use of these flawed data and recommended that CMS delay the implementation of the PPIS data and use the radiology supplemental survey data until a complete analysis of the survey result could be performed. We also requested, but did not receive, early access to the PPIS data and disclosure by CMS of all the formulas that are used for calculating the PE/HR and revised practice expense RVUs to ensure transparency in this important activity.

The ACR is deeply disappointed that CMS disregarded our comments and decided to move forward with implementing the PPIS data in CY 2010 without even providing us the opportunity to review the data during the public comment period.

Any significant change in PE/HR, such as this change of more than 30 percent, must be based on accurate and reliable data that has been evaluated to determine if it reflects reality. Unfortunately, it appears that CMS did not critically evaluate the data and, based on the scant information provided to us to date, it is obvious that there were sufficient problems with the PPIS radiology data to warrant suspension of its implementation. CMS' decision to rely on the PPIS radiology data in the final rule, notwithstanding their obvious flaws, was arbitrary. Our major concerns are summarized below.

The PPIS Should Have Collected PE Data for Radiology at the Practice Level

It appears that the PPIS data are heavily weighted towards hospital-based physicians and that insufficient data are available to reflect the costs of providing radiology services in the office setting. We experienced the same problems with the old SMS survey in 1998, and we were concerned that the PPIS would be unable to capture the true radiology practice expense if the data were collected at the individual physician level rather than at the practice level.

This problem was recognized by Lewin, the CMS contractor with the responsibility to work with specialty societies in designing and conducting supplemental surveys. In its 2005 final report to CMS, Lewin stated:

“The American College of Radiology (ACR) commissioned a practice expenses survey for the specialty of radiology and has submitted the responses to the Lewin Group for CMS consideration as supplemental practice expense survey data. The survey collected data on 2002 practice expenses. ACR has explained to the Lewin Group that many radiology centers employing radiologists are owned by non-physician entities. This same fact has also been reported to the Lewin Group by another organization, the National Coalition for Quality Diagnostic Imaging Services (NCQDIS). These organizations have indicated that these types of centers have become a larger part of the specialty in recent years, as radiology has expanded further into MRI, CT scans, and other technology-driven imaging procedures. As a consequence of these facts, ACR chose to conduct the survey at the practice level, rather than the physician level. This survey method was chosen by ACR after several consultations with the Lewin Group. ***We agreed with ACR that a survey based on physician owners would be unlikely to provide accurate results overall if the non-physician owned segment of the specialty is substantial.*** [emphasis added]. We informed ACR that a practice-level survey would be acceptable, as long as the sample's representativeness of the practice population was verifiable and the data collected could be made to conform to SMS measures. We have previously approved the use of a practice-level survey for supplemental survey data, in the case of independent labs, so this decision has a recent precedent.”¹⁰

¹⁰ Dobson, Allen, Lane Koenig and Jonathan Siegel. “Recommendations Regarding Supplemental Practice Expense Data Submitted for 2005. Evaluation of Survey Data for: Cardiology,

When it became known that CMS intended to work with the AMA and the specialty societies to update the PE/HR data, the ACR petitioned CMS and the AMA to allow the diagnostic radiology component of the PPIS to be conducted at the practice level along the lines of the Radiology Supplemental Survey per our letter dated March 24, 2006 that was submitted before the PPIS instrument was finalized. However, our request was rejected by CMS and the AMA.

The PPIS results for radiology, with a change in PE/HR of more than 30 percent, is not valid on its face. In large part, this result was due to the refusal of CMS and the AMA to design a survey instrument for radiology with a much greater chance for obtaining credible results by focusing on the practice, not the individual physician.

The PPIS Instrument Discouraged Responses from Office-Based Physicians

The ACR believes that the construction of the PPIS made it difficult for office-based physicians to complete as compared to hospital-based physicians. The survey instrument itself was 50 percent longer than the SMS survey making it difficult for any physician to complete as demonstrated by the numbers of physicians who started the survey and failed to complete it. In addition, the hospital-based physicians and employees can look at the survey, determine that they are not involved in radiology practice financing, and say that they have no costs in these areas. This makes it easy for them to complete and be compliant to the process. The Gallup survey organization had only 9 complete surveys for radiology when the process was turned over to dmrkynetec. dmrkynetec did a remarkable job of getting another 45 complete surveys, but could not get the office-based individual physicians to gather all the needed data. Ideally, a radiology business manager would have been allowed to provide this information and would have been able to give more accurate data.

The Response Rate and Precision of the PPIS for Radiology Is Unacceptable

The importance of an adequate response rate and level of precision in determining whether survey data are representative and reliable was established by CMS more than 8 years ago. Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) required CMS to establish a process under which they would accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data normally collected in determining the practice expense component of the physician fee schedule.

In the May 3, 2000 interim final rule with comment period, CMS established the criteria under which they would accept supplemental data.¹¹ In that interim final rule, CMS made the following statement regarding response rates:

Radiology, Radiation Oncology.” Page 11. (Falls Church, VA: The Lewin Group, May 2004).Download from

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS056011&intNumPerPage=10>.

¹¹ 65 Fed. Reg. 25664, (May 3, 2000).

Since the physician fee schedule is a national fee schedule, we require that the survey be representative of the target population of physicians nationwide. We can presume national representativeness if a random sample is drawn from a complete nationwide listing of the physician specialty or subspecialty and the response rate, the percent of usable responses received from the sample, is high, for example, 80 to 90 percent. If any of these conditions (random sample, complete nationwide listing, and high response rate) are not achieved, then the potential impacts of the deviations upon national representativeness must be explored and documented. For example, *if the response rate is low, then justification must be furnished to demonstrate that the responders are not significantly different from non-responders with regard to factors affecting practice expense* [emphasis added]. Differential weighting of subsamples may improve the representativeness.

With this understanding of the importance of the response rate, we reviewed a report titled “Computing Survey Response Rates: A Comparison of the Physician Practice Information and The Supplemental Surveys” that was submitted by the AMA to CMS this year. The report is available for download at <http://www.ama-assn.org/ama1/pub/upload/mm/380/ppi-survey-response.pdf>. The following table compares the response rates of the PPIS for radiology to the ACR supplemental survey, using the AMA’s methodology for calculating response rates:

	PPIS for Radiology	ACR Supplemental
Total sample	2607	1009
Less bad contact information	1673	853
Less ineligible = denominator	1489	687
# of survey completes = numerator	151	182
General response rate	10.1%	26.5%
# with complete PE/HR data = numerator	56	171
PE/HR response rate	3.8%	24.9%

The response rate for the ACR supplemental survey, more than 6 times greater than the response rate for the PPIS and the supplemental survey, was accepted by CMS when it was first submitted. It is inconceivable to us that CMS would replace the PE/HR determined by our supplemental survey with data based on a survey with a response rate of 3.8 percent.

Another important criterion for acceptance of supplemental survey data was the level of precision achieved by the survey. In the November 1, 2000 final rule, CMS established a criterion that required a 90 percent confidence interval with a range of plus or minus 10

percent of the mean (that is, 1.645 times the standard error of the mean, divided by the mean should be equal to or less than 10 percent of the mean).¹² In the June 28, 2002 interim final rule with comment period, CMS revised the precision criteria that a survey must meet to be accepted, indicating they would accept surveys that achieve a sampling error of 15 percent or less at a confidence level of 90 percent.¹³

The ACR supplemental survey achieved a precision level of 13.6 percent¹⁴ and was approved by CMS. The PPIS precision level for radiology was 22 percent.¹⁵ We continue to believe that the inadequate precision of the PPIS should have been sufficient on its own to invalidate the use of the PPIS data for radiology. In the final rule, in response to comments on the proposed rule that objected to the use of the PPIS, CMS, in the final rule, refers readers to an analysis of the comments by Lewin.¹⁶ On the question of precision, Lewin concludes:

The goal of using consistently collected and the most recent information available for as many specialties as possible outweighs the use of precision criteria that would not allow use [sic] to all of the PPIS data which as a whole is the best information currently available on provider practice expenses.

This rationale is illogical and without merit since it is based on the faulty conclusion that the PPIS is the best information currently available. For Lewin to make such a statement is beyond understanding since Lewin is the same CMS contractor that previously reviewed and recommended approval of the ACR supplemental survey that had a higher response rate and greater level of precision than the PPIS. Even worse is the CMS decision to accept such a statement in the face of clear evidence to the contrary.

CMS and the AMA Have Inappropriately Limited Access to the PPIS Data

In April 2009, shortly after the release of summary data from the PPIS, we requested access to the underlying data. A protracted approval process and the execution of confidentiality agreements and other conditions made the data unavailable to us in time to perform any kind of meaningful analysis before the close of the comment period on the proposed rule. In late November 2009, CMS and the AMA released the raw data to dmrkynetec, our CMS/AMA approved consultant. As a result of these delays, our ability to perform the necessary analyses to verify the accuracy of CMS' PE RVUs before the

¹² 65 Fed. Reg. 65383 (Nov. 1, 2000).

¹³ 67 Fed. Reg. 43555 (June 28, 2002).

¹⁴ Dobson, Allen, Lane Koenig and Jonathan Siegel. "Recommendations Regarding Supplemental Practice Expense Data Submitted for 2005. Evaluation of Survey Data for: Cardiology, Radiology, Radiation Oncology." Page 15. (Falls Church, VA: The Lewin Group, May 2004).

¹⁵ Excel spreadsheet "AMA_PPIS_Wkst_3.xls" downloaded from CMS website at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1223902&intNumPerPage=10>.

¹⁶ Downloaded from CMS website at http://www.cms.hhs.gov/physicianfeesched/downloads/Lewin_Group_Analysis_of_Cardiology_Radiology_Urology.pdf.

close of the comment period on the final rule has been severely compromised, and we did not have the opportunity to comment meaningfully on CMS' proposal as a result.

Lack of Access to PE Data files and CMS Formulas

Our ability to comment meaningfully also was substantially compromised because the data files and CMS formulas that would allow us and other members of the public to replicate CMS practice expense methodology have not been made available. This inability to replicate the methodology has made it impossible to determine which aspects of the PPIS are driving down the practice expense RVUs and to understand the impact of the CMS methodology on certain specialties. For example, a corrected Table 1 of the final rule shows that the direct cost adjustment has been reduced to 0.4991.¹⁷ Essentially, CMS now recognizes less than half of the direct costs of the services paid under the physician fee schedule. We believe this step in the calculations systematically disadvantages specialties such as radiology with high direct costs. However, without access to the underlying data files and the formulas used to calculate PE RVUs, we cannot test our hypothesis or model alternative approaches. Until a reasonable time can be allowed for us to replicate the CMS practice expense methodology so that we can comment meaningfully on it, the PPIS data for radiology should not be used.

CMS Can Exercise Its Discretion and Use the ACR Supplemental Survey Data

CMS seems determined to apply the PPIS data uniformly across all specialties that are paid under the physician fee schedule, despite strong and convincing arguments by some specialties that the use of the PPIS data is inappropriate because more accurate and reliable data is available and/or because the PPIS results are invalid on their face.

We note that CMS set a precedent for the use of supplemental survey data in lieu of PPIS data for the medical oncology specialties in the final rule. In response to comments that section 1848(c)(2)(H)(i) of the Social Security Act requires CMS to continue to use the supplemental survey data for oncology, CMS revised the PE/HR for medical oncology, hematology and hematology/oncology to reflect the continued use of these supplemental survey data. We have reviewed this statutory provision and have concluded that CMS must have exercised its discretion to use the supplemental survey since we do not believe Congress intended for 2002 survey results to be used forever. If the PPIS data showed an increase in PE/HR, would CMS have replaced it with 8 year old supplemental survey data because of the statutory language? We do not think so.

Given that CMS replaced the PPIS data with the medical oncology supplemental PE/HR data, we believe that CMS also should continue current radiology reimbursement levels until appropriate survey data can be utilized.

RUC Recommendations for New Codes

The ACR disagrees with the CMS decision to reject the RUC recommended values for diagnostic CT colonography (CTC) and myocardial perfusion.

¹⁷ 74 Fed. Reg. 65449, 65451 (Dec. 10, 2009).

CT Colonography

CPT 2010 includes 3 new codes for CT colonography. The RUC recommendations and the CMS decisions for these 3 codes are shown in Table 1 below:

Table 1: CT Colonography Work RVUs				
<i>Code</i>	<i>Description</i>	<i>RUC Rec Work RVU</i>	<i>CMS Decision</i>	<i>CMS 2010 Interim Work RVU</i>
74261	CT colonography, w/o dye	2.40	Disagree	2.28
74262	CT colonography, w/dye	2.50	Agree	2.50
74263	CT colonography, screen	2.28	Agree	2.28

For the CTC code, 74261 (Computed tomographic colonography, diagnostic, including image postprocessing; without contrast material), we disagree with the CMS decision to reduce the RUC recommended work RVU to 2.28. During the RUC meeting, this code was compared to 2 codes: 75635 (CTA, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing) with a physician work value of 2.40 and 78815 (Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh) with a work value of 2.44.

Based on the comparisons of the work value, physician time and intensity/complexity measure, the RUC determined that the work value of 2.40 was appropriate for code 74261. To have simply equalized the RVUs of diagnostic and screening CTC ignores the fact that patients referred for diagnostic study, by definition, have greater complexity. For this reason, we recommend a work RVU of 2.40 for code 74261 to maintain the proper relativity with the corresponding screening code 74263. If CMS does not agree, the ACR requests that code 74261 be reviewed by the Refinement Panel.

Myocardial Perfusion

CPT 2010 includes a restructuring of the family of codes for myocardial perfusion imaging. The major change was to package two add-on codes (78478 and 78480) into the codes for Single-Photon Emission Computed Tomography (SPECT) and planar imaging after analysis of claims data indicated that they are commonly done together 90 percent of the time. The 2009 and 2010 codes and work RVUs are listed in Tables 2 and 3 below:

Table 2: 2009 Myocardial Perfusion Imaging Codes		
<i>Code</i>	<i>Description</i>	<i>2009 Work RVUs</i>
78460	Heart muscle blood, single	0.86
78461	Heart muscle blood, multiple	1.23
78464	Heart image (3d), single	1.09

78465	Heart image (3d), multiple	1.46
78478	Heart wall motion add-on	0.50
78480	Heart function add-on	0.30

Table 3: 2010 Myocardial Perfusion Imaging Codes

<i>Code</i>	<i>Description</i>	<i>2010 Work RVUs</i>
78451	Ht muscle image spect, sing	1.38
78452	Ht muscle image spect, mult	1.62
78453	Ht muscle image, planar, sing	1.00
78454	Ht musc image, planar, mult	1.34

The packaging of the add-on codes into the two codes for planar imaging (one for a single study and one for multiple studies) and into the two codes for SPECT imaging (one for a single study and one for multiple studies) resulted in a significant net decrease in work RVUs based on the RUC recommendations.

For myocardial perfusion imaging (MPI) studies that included both add-on codes in 2009, the corresponding work RVUs for these same studies in 2010 are reduced as shown in the table below, which compares the RUC recommended work RVUs for 2010 to the 2009 work RVUs.

Table 4: Myocardial Perfusion Imaging Codes and Work RVUs

<i>Study</i>	<i>2010 Code</i>	<i>2009 Codes</i>	<i>2010 RUC Rec Work RVUs</i>	<i>2009 Work RVUs</i>	<i>% Change</i>
Ht muscle image spect, sing	78451	78464 + 78478 + 78480	1.40	1.66	-20.3%
Ht muscle image spect, mult	78452	78465 + 78478 + 78480	1.75	2.26	-39.5%
Ht muscle image, planar, sing	78453	78460 + 78478 + 78480	1.00	1.66	-66.0%
Ht musc image, planar, mult	78454	78461 + 78478 + 78480	1.34	2.03	-51.5%

Despite these reductions, CMS rejected the RUC recommendations for codes 78451 and 78452, decreasing the work RVUs to 1.38 and 1.62, respectively. We are extremely disappointed that CMS did not accept the RUC recommendation for the valuation of codes 78451 and 78452 and instead instituted a further cut based on an arbitrary decision to use another reference code. No CMS objections had been raised at the RUC after a rigorous vetting process. We respectfully request that CMS reconsider and accept the AMA RUC recommendations for 78451 and 78452.

We believe it was inappropriate for CMS not to accept 70496 (Head CTA with and without contrast including post processing - valued at 1.75 RVUs) as the reference code for 78452, and instead substitute 73219 (MRI, upper extremity, other than joint, with contrast at RVU 1.62). CPT code 73219 has no computer post-processing analysis associated with it, has less overall images to interpret, and has no additional cine motion images to analyze and interpret, all of which are included in the MPI procedures. The differential diagnosis, patient complexity/history, and cognitive assessment for good patient outcomes are frequently a different level in the cardiovascular patient. We would also like to point out that CPT code 70549 (MR angio, neck, with and without contrast) with pre, intra and post-service times of 10, 20 and 10 minutes and 1.80 work RVU was seriously discussed as a possible reference code at facilitation committee before a consensus agreement chose 70496 (valued at 1.75 with pre, intra and post-service times of 8, 20 and 10 minutes). The physician time approved by the RUC for 78452 (10, 20 and 10 minutes) accurately reflect the time required to perform this service. The ACR recommends that CMS accepts the RUC recommended work value of 1.75 for 78452.

CMS stated that it was unclear what methodology was used to calculate the recommended RVU for 78451. It will be described again here. The RUC, in an effort to maintain relativity between 78451 and 78452, derived the recommended RVU for 78451 by calculating the relationship between the median survey RVUs of 78451 and 78452 and maintaining this relationship between the recommended RVU for 78451 and 78452. The survey work RVU relationship between 78451 : 78452 is (1.50 : 1.87) resulting in a relationship between the recommended RVU for 78451: 78452 (1.40 : 1.75).

$$\begin{array}{l} 78451 = \frac{1.50}{1.87} \frac{1.40}{1.75} \\ 78452 = \end{array}$$

The RUC agreed that this computed work RVU, 1.40 RVUs, maintains the relativity of the original survey data and is an appropriate measure of the work for 78451. In addition, the RUC looked at the time and work value of 45308 (Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery) and agreed that the work value of 1.40 is appropriate for code 78451. Therefore, the ACR recommends that CMS accepts RUC's recommendation of work value of 1.40 for code 78451.

If CMS does not agree with RUC's recommendation for codes 78451 and 78452, the ACR requests that these codes be reviewed by the Refinement Panel.

Lack of a Transition Period for Established Services with “New” CPT Codes

In the final rule, the practice expense values for several “new” codes did not reflect the 4 year transition period described in the final rule. In the interest of fairness, we ask that CMS apply the 4 year PE transition to any “new” code that describes services that were reported in 2009 by one or more predecessor code(s) with established RVUs. For example, the myocardial perfusion imaging codes 78451, 78452, 78453 and 78454

describe services that have been recognized under the physician fee schedule since it was first implemented in 1992. To call these services “new” and deny them the benefit of a transition period is unreasonable and should be corrected for 2010. Table 5 below lists the current 2009 PE RVUs for the codes that correspond to the “new” codes in 2010 and includes the calculated transition values (75 percent 2009 value and 25 percent of the fully implemented value).

Table 5: Myocardial Perfusion Imaging Codes and Recommended 2010 PE RVUs						
<i>Study</i>	<i>2010 Code</i>	<i>2009 Codes</i>	<i>2009 PE RVUs</i>	<i>CMS 2010 PE RVU (Transition)</i>	<i>CMS 2013 Fully Implemented PE RVU</i>	<i>Calculated 2010 PE RVU (Transition)</i>
Ht muscle image spect, sing	78451	78464 + 78478 + 78480	8.1	4.73	4.73	7.26
Ht muscle image spect, mult	78452	78465 + 78478 + 78480	13.31	8.84	8.84	12.19
Ht muscle image, planar, sing	78453	78460 + 78478 + 78480	6.12	4.32	4.32	5.67
Ht musc image, planar, mult	78454	78461 + 78478 + 78480	6.3	3.77	3.77	5.67

We request that CMS publish a correction notice with the PE RVUs calculated according to the transition formula and shown in the table above. We also ask that CMS make similar calculations for the “new” dialysis access codes (36147, 36148 and 75791), nerve injection codes (64490 – 64495) and the code for cardiac flow velocity mapping (75565), all of which had previous inputs with their “old” codes. We would also ask that fiducial marker placement (32553 and 49411) and tunneled pleural catheter (32552) be allowed a similar phase-in period. Furthermore, CTC (74261 – 74263) and Coronary CT Angiography (CCTA) (75571 – 75574) are services that were established as Category III

codes for years and as such are not “new services” and the practice expense values for these should also go through a 4 year transition.

Practice Expense Inputs for 2010 New Codes

For the coronary CTA codes, 75572 and 75573, CMS did not capture the equipment and some of the medical supplies used to provide these services and accepted by the RUC. To ensure all appropriate practice expense items are captured and therefore appropriate practice expense RVUs, the ACR requests that CMS relook at all the practice expense inputs for the new 2010 codes.

Physician Quality Reporting Initiative (PQRI) Registry-Based Reporting Mechanism

The ACR supports the CMS decision to continue offering claims-based reporting options for PQRI beyond 2010 and is encouraged that CMS recognizes that for many eligible professionals, claims-based reporting is the only option available for participating in PQRI. Although, the ACR recognizes the limitations associated with claims-based reporting of PQRI measures and the benefits of registry reporting of measures, we urged CMS to not totally discontinue claims-based reporting for several reasons: 1) numerous practice locations where the radiologist may not control data needed to report to CMS; 2) the cost to utilize a registry and 3) the inability to report 3 measures making them ineligible for registry reporting.

Reporting Periods

The ACR is pleased that CMS has provided for an additional reporting period of 6 months (July – December) for claims-based reporting in 2010. This will increase the potential of successful reporting for more radiologists. The option of 6 month reporting will provide even greater flexibility if participants who begin reporting in January 2010 are provided with interim feedback reports for January – June 2010, in order to evaluate their success in reporting and to modify processes, if necessary, to correct these processes for the remainder of 2010. The ACR urges CMS to provide such timely feedback.

Minimum Patient Sample Requirement – Individual Measures

The ACR supports CMS’ decision to not move forward in 2010 with the proposed additional successful reporting criterion of a minimum patient sample size for at least one measure. Until the time that the successful reporting rate has increased substantially, CMS should carefully consider adding more complexity to the program.

Public Reporting of PQRI Data

CMS has finalized its intention to post “enhanced” information related to PQRI reporting on the Medicare Physician Directory, e.g. names of professionals who: 1) submitted data on PQRI quality measures; 2) met satisfactory reporting criteria for 2010 PQRI and 3) qualified to earn a PQRI incentive payment for services in the 2010 reporting period.

Although CMS indicates that it believes many suggestions and concerns submitted by commenters have been addressed, including allowing eligible professionals to have an opportunity to review their reporting results prior to public posting and accompanying publicly reported information with a disclaimer that addresses the potential uses and limitations of the information, the ACR continues to have great concern on a PQRI “report card” at this point in time for several reasons. Many measures are poor surrogates for achieving quality, and to have report cards on providers who are not “successful” in reporting them is problematic. Even if there is a specific disclaimer provided with the “enhanced data” outlining their limitations as a representation of the provider’s quality, i.e., reporting vs. performance, will the lay public be able to understand the difference? “Dr. Smith was not successful in this quality program, maybe I should change doctors.”

Additionally, until the participants of PQRI have been given detailed feedback as to why they were not successful – allowing the opportunity to correct processes in order to be successful—public reporting of their success or “failure” is premature. Anecdotally, many radiologists have been proactive, conscientious and determined in their PQRI reporting, yet have failed to obtain the bonus and will not be listed on the Medicare Physician Directory as a physician of success. They have yet to resolve the reason for different claim counts than reported on their feedback reports, even with resource-intensive, meticulous internal tracking. This process is not transparent and creating physician report cards when there is no way to test the validity of CMS’ analysis and scoring, or an appeal process, is troubling. This is an issue that impacts all professionals attempting to participate in the program and who are undermined by unknown errors.

The ACR urges CMS to reconsider the inclusion of “incentive payment obtained” in publicly reported PQRI data until such time that a greater percentage of participants do so.

Conclusion

Thank you for the opportunity to comment on this final rule. We are gravely concerned about patient access to imaging services in 2010 and beyond and urge you to continue current radiology reimbursement levels until appropriate equipment utilization assumptions and survey data can be incorporated. If you have any questions about our comments or need more information, please contact Angela Kim at 800-227-5463 ext. 4556 or via email at akim@acr-arrs.org.

Respectfully Submitted,



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