January 3, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1524-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Final Rule; CMS-1524-FC

Dear Acting Administrator Tavenner:

The American College of Radiology (ACR), representing more than 34,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the 2012 Medicare Physician Fee Schedule (MPFS) Final Rule with comment period.

In this comment letter we address the following important issues:

1. **The Professional Component Multiple Procedure Payment Reduction (MPPR)**
    - While we appreciate CMS' recent decision not to apply a professional component MPPR to procedures on the same patient interpreted by different physicians on the same day, we believe that for payment policy purposes, the Agency should acknowledge that the interpretation of examinations on the same patient on the same day by different physicians by definition constitutes a distinct and separate session.
    - We believe the MPPR disadvantages small and/or rural practices where the same physician will have to interpret all examinations on the same patient on the same day, since for payment policy purposes it will be difficult for coders, CMS contractors and auditors to retrospectively determine which examinations constituted the same or different sessions. This can only be judged by the interpreting physician, and CMS should recognize that the MPPR policy would cause a significant increase in the appropriate use of the 59 modifier.
    - We believe CMS own internal review of the eight most common services performed together reinforces our opinion that any efficiencies are highly variable depending on the examinations performed and a systematic reduction

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over all advanced imaging procedures and across all modalities is inappropriate and should be determined on a code-by code basis.
- We appreciate CMS acknowledgement that at 50 percent the magnitude of the reduction was inappropriately high. We also appreciate the opportunity to comment on CMS' methodology supporting the magnitude of a 25 percent MPPR, which was first described in the Final Rule. After our teleconference with CMS medical officers we continue to believe that even at the reduced value of 25 percent, the magnitude of the MPPR remains inappropriately high as efficiencies assumed by the Agency do not exist in clinical practice.

2. **Finalizing CY 2011 Interim and CY 2012 Proposed Values**
   - We are concerned with CMS' insistence that the component codes of newly bundled procedures be re-reviewed by the AMA-Specialty Society Update Committee (RUC). CMS' stated rationale for re-valuation has been in part predicated on erroneous practice expense inputs and inconsistent calculation of room time and equipment usage. Additionally, CMS' failure to recognize that bundling of the services constitutes a re-review of the base services creates a potentially never ending cycle of further RUC reviews at a time when the entire process is asymmetrically taxing the resources of some specialty societies and their physician volunteers.
   - We are concerned by CMS' unilateral adjustments to practice expense inputs and the Agency's flawed methodology in the calculation of room time. CMS should continue to rely on the input of the RUC and adhere to the established conventions for determining room time and equipment usage.
   - In this comment letter, we make numerous corrections and suggestions for practice expense inputs on a code-by-code basis that should be addressed by the Agency as soon as possible.

3. **The Physician Quality Reporting System**
   - While we appreciate the complexities of developing a quality reporting system applicable to all medical specialties, radiologists have had a particularly difficult time in reporting the specific measures. We believe the Agency should continue to work with imaging stakeholders to develop an array of appropriate measures applicable to radiologists.
   - Since radiologists do not control the utilization of the services they provide, CMS must carefully consider how it will attribute costs associated with inappropriate utilization

<u>Multiple Procedure Reduction (MPPR)</u>

Since the publication of the Final Rule, the ACR has vigorously voiced our concern to the Agency in both written comments and in meetings with CMS officials over the unexpected expansion of the application of the MPPR to the professional component (PC) of multiple procedures performed by a single physician to procedures performed by multiple physicians in the same group practice. We are grateful that the Agency took our

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comments into consideration in its decision to rescind this portion of the policy for CY 2012. However, we are concerned that the rationale for this decision was based solely on administrative and operational burdens that the CMS contractors would have faced in order to apply this policy in such a short timeframe. We again would like to emphasize and reiterate our comments that the application of the MPPR to physician group practices does not take into account the practical realities of how radiology is practiced and that any application of a MPPR to the PC should follow the language in the notice of proposed rulemaking (NPRM): "***reduction to the PC of the second and subsequent advanced imaging services furnished by the same physician to the same patient, in the same session, on the same day***" **[emphasis added]**. We believe that by definition it is a distinct and separate session when two physicians are involved in providing professional services to a patient on the same day, and we find it difficult to imagine what efficiencies could possibly be achieved in CY 2012, or in any subsequent year, when more than one radiologist is involved in furnishing the professional components of multiple advanced imaging services. Therefore, contrary to what CMS states in the Final Rule, we expect there would be frequent circumstances requiring the use of the 59 modifier if the policy is ever extended to group practices.

We also remain troubled that radiologists in small practices or rural hospitals and imaging facilities will be more affected by the MPPR policy than physicians in larger practices, as frequently there is only enough volume to support a single radiologist in rural locations. Frequently in small practices, there will be instances where patients have multiple advanced imaging services that are in clinically separate sessions, but interpreted by the same radiologist. It is not clear to us that there will be a way for coders, CMS contractors and auditors to understand that these encounters constitute separate sessions. CMS should anticipate an appropriate increase in the use of the 59 modifier, as this is the only vehicle physicians will have to convey that the multiple interpretations constitute separate clinical sessions. Small practice and rural radiologists are providing a valuable and much needed service to areas of the country that are often in remote locations, and should not be penalized for providing efficient care. CMS should be mindful of the possible unintended consequences of the MPPR policy in its current form, and the implications for any future expansion, including limiting access to care.

Despite our recent meetings with CMS staff and medical officers in an attempt to understand the rationale for determining the magnitude of the PC MPPR reduction, the ACR remains extremely concerned about the methodology that CMS used to arrive at the 25 percent reduction. While the magnitude of the reduction has been revised downward from the 50 percent reduction that was originally proposed in the NPRM, we remain firm in our belief that even a 25 percent reduction is unfounded. Further, we reiterate our previous comments made to former Administrator Berwick that there continues to be no publicly available empirical analysis to support a 25 percent reduction. CMS' qualitative analysis showed, as we have suggested, that efficiencies in the multiple procedure setting are highly variable, even within the same modality. **We attempted to replicate the analysis CMS conducted using the code pairs that were presented in Table 8 on**

page 73076 of the Final Rule and again found that any potential efficiencies in these high volume code pairs would be less than 10 percent.

We appreciated the opportunity to talk to the CMS experts who were involved in the CMS study of frequently billed advanced imaging combinations on December 13. Unfortunately, our questions about the methodology used in the development of the proposed reduction were not answered to our satisfaction. Among other things, we remain concerned about the following:

- The failure of CMS experts to review with ACR representatives how CMS assessed the full array of efficiencies for any of the sample code pairs in Table 8 of the Final Rule. Based on the statements in the Final Rule, we expected to see work sheets and other information that would detail which activities in the vignettes were assigned reduction percentages of 0, 25, 50, 75 and 100 percent and discuss the clinical aspects that went into those decisions. This information would have been valuable in walking the ACR representatives through the entire CMS thought process.

- The lack of information, written or verbal, that would allow the ACR to attempt to replicate the CMS methodology. From our teleconference with CMS experts, it appears that work sheets or other empirical analysis were not generated. Based on the comments of the CMS experts, the reductions for each code pair were based primarily on a global perception of what efficiencies might exist in each particular service. This process is very different than the line-by-line analysis that was suggested in the Final Rule.

- The CMS clinical assessment of the 12 code pairs in Table 8 assumes a significant reduction percentage for intra-service work. Specifically, our analysis indicates that pre- and post-service work together account for 14.5 to 29 percent of the total work in these code pairs. Our experts believe that in these code pairs, maximum efficiency in the pre-service period would be no more than 20 percent, and would be no more than 27 percent in the post-service period for the second services. Further, we explained in detail why many of the pre-service activities (including prior imaging review and protocol management) and post-service activities (including editing and signing a completely separate report for each service) have little, if any, overlap in work when two services are performed. However, even if a 100 percent reduction percentage for pre- and post-service work was assumed, CMS also had to assume there were 12 to 22 percent efficiencies in the intra-service period. We tried to understand CMS' logic for making these determinations; however, the explanations by the clinical experts seemed qualitative and perceptual rather than empirical and appeared to assume efficiencies that in practice do not exist. Our analysis of the vignettes and physicians' times from the database for these code pairs does not support a finding of any significant and reproducible efficiency in the intra-service work.

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- CMS makes assumptions regarding where intra-service efficiencies might exist in interpreting cross-sectional imaging and the application of these perceived efficiencies to the interpretation of multiple studies. CMS asserts that "multiplanar imaging and image rotation and zoom using shuttles and joysticks" enhances pattern recognition making interpretation more efficient. We agree that electronic image manipulation, most commonly performed with a standard computer mouse, facilitates soft-copy review of data sets that often include over 1000 images and that in fact, modern imaging interpretation would not be possible without it. However, soft-copy review does not add any efficiency whatsoever when multiple examinations are interpreted, and we could not ascertain from the CMS clinical experts why soft-copy review techniques would be a rationale to support a PC MPPR. It would be unusual for multiple examinations to even be included in the same data set for review, even for contiguous body areas (e.g., thorax and abdomen) due to different phases of contrast and specific window and level settings. We also reminded the Agency that any efficiency in interpretation that might accrue from soft-copy review is mitigated by the fact that hundreds of images are interpreted for each examination, all of which include multiplanar imaging. Furthermore, CPT code 76375 (Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality), which accounted for 1,027,175 uses and $46,143,685 million in spending in 2005, was deleted at the request of the ACR in 2006. At 0.22 RVU, 76375 contributed to approximately 15 to 20 percent of the physician work of cross-sectional image services and its deletion economically offsets any efficiencies of soft-copy review.

- Inadequate knowledge of how radiologists interpret imaging studies impacts CMS' decisions about intra-service efficiencies. At our December 13 conference call, ACR representatives were surprised to learn that CMS experts believe that by knowing the general diagnosis (cancer, trauma, stroke, etc.), the detailed image-by-image interpretation of the examinations typically performed by radiologists would be more efficient when two studies were performed than when a single study was performed. However, the CMS experts never made the basis of this belief clear enough for us to respond other than to reiterate that the same rigorous attention to detail must be applied to each image no matter whether one or two studies are interpreted; and that in fact the need to scrupulously measure changes in metastasis size, or a change in some other pathologic disease process, will always increase the amount of time needed to interpret a follow-up study, as opposed to a de novo study in a given patient. For this reason, in our analysis, we considered efficiencies in intra-service work, such as supervision of contrast and over-lap in images of contiguous body parts, to be *de minimis*. Hopefully, we made this clear in our meeting with the CMS experts and ask CMS to reconsider its assumption that there are significant intra-service efficiencies when multiple examinations are interpreted on the same patient.

- CMS continues to apply a single reduction percentage for the MPPR when CMS' own clinical assessment showed large variations (27 percent to 43 percent) in efficiencies in the Table 8 code pairs, which were all in the same modality and across the same or adjacent body regions. We believe these reduction percentages would be significantly lower and even more variable had CMS looked at services performed using different modalities and non-contiguous body regions. As such, we see no justification for extending the policy across modalities or non-contiguous body regions. We find the explanation that these types of services comprise only a small percentage (3 percent) of multiple services particularly unsatisfying, as it is not based on transparent and proper payment policy and implies that the physicians should be reimbursed at a decreased payment level even when there is no measurable efficiency in performing the services.

It was somewhat surprising to learn that CMS primarily used a qualitative analysis to reach its conclusions in determining the percentage for a multiple procedure payment reduction. We consider this a change in position by the Agency since recommendations by the Government Accountability Office (GAO) and the Medicare Physician Advisory Council (MedPAC) were based on an empirical analysis of the resource-based relative value scale (RBRVS) Data Manager information, and we previously assumed that this type of analysis replication would be done by CMS. We presume that CMS expanded its rationale to include this qualitative assessment after realizing that empirical analysis of the relative value scale (RVS) data alone does not support the magnitude of the presumed efficiencies iterated in the NPRM. However, from a qualitative perspective, it makes even less sense that there are significant efficiencies in the interpretation of multiple procedures on the same patient. We will not reiterate our previous comments on the NPRM, but we remind the Agency again of Dr. Berwick's qualitative conclusions after visits to imaging facilities in the Midwest where he stated that he saw very little efficiency in the interpretation of multiple procedures on the same patient.

In conclusion, despite our interactions with CMS officers since the release of the Final Rule, the ACR stands by our original comments made in response to the NPRM and supported by numerous stakeholders, many of whom provide imaging services on a regular basis. We do not believe the CMS clinical assessment described in the Final Rule and explained at our follow-up meetings constitutes the systematic review called for by MedPAC and the GAO. To our knowledge, the analysis of the RBRVS Data Manager data published in the *Journal of the American College of Radiology* [*Journal of the American College of Radiology* 2011; 8(9): 610-616] continues to represent the only systematic review of the existing vignettes and data. Even after hearing CMS' clinical experts explain the Agency's analysis, we stand by our conclusions that any potential efficiency for multiple imaging examinations is highly variable and less than 10 percent. We believe that the search for professional component efficiencies when multiple procedures are performed together should be limited to the RUC process, which evaluates services that are performed together on a code-by-code basis and includes clinical review and specialty input in determining the efficiencies. CMS has stated it will consider expanding the MPPR policy across all of diagnostic imaging as part of future rulemaking,

and once again we urge the Agency to consider our published analysis in this process to understand the small magnitude of the potential efficiencies in the pre- and post-service periods. We suggest CMS consult with the ACR and other stakeholders if there is a belief that intra-service efficiencies for the other modalities exist, as none of the efficiencies of soft-copy review described in the Final Rule apply to the remaining modalities.

Finalizing CY 2011 Interim and CY 2012 Proposed Values

We recognize that the primary purpose of the comment period is for CMS to receive input on codes with interim values in 2012, and we have comments on the following issues.

Table 19 (CY 2012 New, Revised and Potentially Misvalued Codes)

We appreciate the fact that CMS agreed with the AMA/Specialty Society Relative Value Scale Update Committee (RUC) recommendations for CPT® codes 70470, 72100, 72110, 72114, 72120, 72170, 73030, 73620, 74174, 77435, 77469, 78226, 78227, 78579, 78580, 78582, 78597, and 78598, and therefore, we will not be seeking refinement.

Again, we are pleased that the RUC recommendation for 74174 (*Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing*) was accepted, but do not understand CMS' "request that the AMA RUC review the component CPT codes: 74175 (*Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing*) and 72191 (*Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing*). The RUC operates under the premise that the value of all codes in the RBRVS are assumed to be accurate and the individual codes 74175 and 72191 were used as important building blocks in the valuation of 74174. Accordingly, the RUC considered their individual values, which in many ways should equate to a RUC review. Is CMS requesting a review of individual codes simply because they were bundled? To review individual codes solely because they were bundled risks rank order anomalies within families, which could threaten the relativity of the RBRVS. We are concerned that should the individual component codes increase in value, an increase in 74174 would be necessary to maintain relativity. We wonder if this increase in 74174 would trigger another review of the base codes and when such a disruptive cycle of requests would end. We strongly suggest CMS reconsider its request for additional RUC review of this family of codes and future code pairs that are bundled into a distinct clinical service.

We are also concerned with CMS' rejection of the refinement panel's recommendation for CPT code 36247 (*Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family*). We appreciate CMS acknowledging that the discussion of the global period in the Fourth Five-Year Review Proposed Rule inaccurately referred to the previous global

period as 90 days when the previous global period was actually XXX. However, we are confused by CMS' rationale for not accepting the refinement panel's recommendation of 7.0 RVUs "notwithstanding that the survey was conducted for a 0-day global, which includes an evaluation and management (E/M) service on the same day." The addition of an E/M would be a justification for the higher value, not contradictory to a higher value. Further, the societies provided a compelling rationale why the change in patient population warranted the increased value and provided valid reference services. We appreciate that CMS has made the assignment of 6.29 RVUs and 0-day global interim for 2012 and hope CMS will again review the RUC's and the refinement panel's recommendations. The circumstances leading to these recommendations have not changed and if CMS continues to disagree with these recommendations, we hope CMS will provide a more appropriate reason.

We, furthermore, are concerned regarding comments made in the Final Rule suggesting that CMS will "more critically evaluate the need to refer codes to refinement panels in future years, specifically considering any new information provided by commenters." The "new information" request ignores the fact that considerable information has already been provided by the specialties through the normal RUC processes and subsequent comment letters. CMS further justifies this change based on a need "to make the best use of the agency's limited resources," which is equally puzzling since it is the volunteer time of dozens of physicians, that becomes duplicative when CMS rejects RUC recommendations with little or no rationale provided.

CMS designed the refinement panel process to serve as a valuable appeals process when the RUC or another public commenter and CMS disagree. The availability of this additional venue for stakeholders is critical to maintaining the transparency and credibility of the Medicare Physician Fee Schedule (MPFS).

Table 7 (Select List of Procedural Codes Referred for AMA RUC Review)

We appreciate comments made by the agency recognizing that there are some specialties that have been inordinately burdened by the screening process for potentially misvalued services. The screening processes initiated by the RUC, CMS and reiterated in the Patient Protection and Affordable Care Act (PPACA) all have bias that preferentially select services performed by radiology for review, and at the same time protects low volume, high RVU services from being captured for review. For example, in the review of Harvard-valued services, an annual utilization volume of more than 30,000 services was considered an appropriate floor at which to terminate the RUC reviews. However, this illustrates the selection bias for low RVU services and how low volume, high RVU services are protected from review. For instance, 30,000 services at 1 RVU have the same impact as 1,500 services at 20 RVUs. Additionally, the lack of granularity in the radiology code set means a higher performance volume for the individual codes and greater exposure to the screens. Consider that there are only 75 imaging CPT codes used for diagnosis of all of the possible diseases of the abdomen and pelvis. In contrast, there are 777 unique surgical codes used to treat those same diseases of the abdomen and

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pelvis, which means that more granularity in the code set of a particular specialty protects their individual services from being captured in the screening processes. This again illustrates the significant selection bias faced by radiology.

Further, there is great variability in the way radiology services are delivered on a patient-by-patient basis, and our reporting system allows us to report the various components of care individually. This allows a very granular means of describing our encounters, but leaves us especially susceptible to screens for “services reported together.” Indeed, many interventional radiology services inherently include both surgical and supervision/interpretation codes leading to significant selection bias for these families of services.

Finally, low intra-service times for imaging services allows radiologists to spend time providing a high volume of services to multiple patients; whereas, 90-day global surgical services, typically, have longer intra-service times (median 120 minutes) meaning fewer services can be provided each day. For these reasons, the impact on radiology has been far greater than on other specialties. Note that even within Table 7, radiology has a higher percentage of services for consideration than any other specialty. We are, therefore, surprised that CMS decided not to withdraw their request to review radiology services in the same spirit as they did with the proposed review of the E/M codes. As we mentioned in our comments on the proposed rule, many of the 11 radiology codes listed in Table 7 appear on other CMS screens and were already on track to be reviewed. <u>By finalizing their request for review of the codes listed in Table 7, CMS has accelerated the timeline for review of these services. This requires significant redistribution of our limited resources at a time when we are already overburdened with many other mandated code reviews.</u>

Consolidating Reviews of Potentially Misvalued Codes

We support CMS’ proposal to consolidate periodic reviews of work and practice expense (PE) relative value units (RVUs). We are concerned with certain comments made regarding the relativity of PE RVUs within the MPFS. We agree with the following CMS comment that “the code-specific resource based relative value framework under the PFS system is one in which services are ranked relative to each other. That is, the work RVUs assigned to a code is based on the physician time and intensity expended on that particular service as compared to the physician time and intensity of the other services paid under the PFS.” We have concerns, however, with the subsequent statements that “this concept of relativity to other services also applies to the PE RVUs, particularly when it comes to reviewing and assigning correct direct PE inputs that are relative to other similar services” and “that less intensive services and/or services that require less physician time and/or require fewer or less expensive direct PE inputs should be assigned lower work or PE RVUs relative to other codes within the family.” CMS must understand that PE RVUs are determined by a complex PE methodology in which direct costs are only one variable used in the PE RVU calculation. Other variable data sets including indirect costs and direct:indirect ratios are also factored into the RVU

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determination. These variables are specialty-specific, and are now largely determined by the Physician Practice Information Survey (PPIS) survey data which we have expressed in previous comment letters is under-representative of office-based radiology practices. Hence, it is possible that occasional anomalies may occur within families, unrelated to the direct inputs themselves. Accordingly, we urge CMS to consider their own methodology when retrospectively refining PE inputs for established codes and when requesting that the RUC re-review PE RVUs as "potentially misvalued."

Establishment of Interim Final Direct PE Inputs

We are concerned that the agency is establishing interim final direct PE inputs for several codes for which the RUC did not provide direct PE recommendations. The affected radiology CPT codes are 74175 (*Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing*) and 72191 (*Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing*), which have been combined into 74174 (*Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing*). Since each of these sets of component and combined codes is used to report the same service, we agree with CMS that it is important to maintain relativity among the associated practice expense values. However, the process, review and development of these inputs should occur at the RUC. We disagree with the statement "the new direct PE inputs for the combined services are not fully congruent with the current direct PE inputs for the component codes." For example, CMS has significantly reduced the CT room time for the individual abdomen CTA and pelvis CTA codes from 61 and 55 minutes, respectively, to 40 minutes. This is presumably because the RUC recommended CT room time for the combined code is listed in Table 21 as 82 minutes when the actual RUC recommendation was 121 minutes, which CMS apparently reduced to 57 minutes without providing a rationale. CMS may be concerned that the combined time for the individual codes (61+55=116) would be higher than the CT room time for the bundled code 74174. However, CMS may be failing to consider the TC MPPR (a policy which at 50% continues to have a number of technical flaws), which would reduce the time for a "combined" study to 88.5 minutes [61 + (55/2)], well below the 121 minutes of time recommended by the RUC. Therefore, it is actually CMS' unilateral reductions in time combined with a failure to apply its own TC MPPR policy, which have led to the perceived rank order anomalies. Accordingly, we ask that the existing times and values for the component codes be restored. Should further review of the base codes be considered again, we suggest that the RUC PE subcommittee provide CMS with that input.

The agency also established interim final direct PE inputs for codes where physician work values of the codes were reviewed as part of the misvalued code initiative without parallel RUC review of the corresponding direct PE inputs. Codes affected in this case for CY 2012 are five imaging codes: 70470 (CT head/brain w/o & w/dye), 72170 (x-ray pelvis), 73030 (x-ray shoulder), 73620 (x-ray foot), and 93971 (extremity study). We

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reiterate that the work of developing PE inputs should occur as part of the RUC process. In fact, CMS has indicated that all codes henceforth identified through a screen for work or PE shall have both the work and PE reviewed concordantly. We look forward to working with the PE Subcommittee to ensure that the existing direct PE inputs for our codes are accurate and reflective of the standards created by the PEAC. We regret that CMS' retrospective refinement did not allow us this venue, but we hope to work with the CMS staffers responsible for the PE database on correcting these shortcomings. To this end, we have included specific comments on these refinements below.

CMS PE Database

For some of the codes, CMS has substituted stretcher chair with a table, instrument, mobile, citing that the stretcher is a non-standard input for moderate sedation. We request that CMS clarify why and when this change took place and ensure that the correct input is in the database.

The ACR has noted the following issues and discrepancies that should be addressed and/or corrected in the CMS PE Database:

X-ray Spine Codes

72100 (Radiologic examination, spine, lumbosacral; 2 or 3 views)

72110 (Radiologic examination, spine, lumbosacral; minimum of 4 views)

72114 (Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views)

72120 (Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views)

Basic radiology room times for codes 72100, 72110, 72114, and 72120 in CMS practice expense database are 13 minutes, 19 minutes, 25 minutes, and 15 minutes, respectively. We disagree with the assigned room times for these codes. The room times should be corrected and changed from 13 minutes to 20 minutes, 19 minutes to 28 minutes, 25 minutes to 36 minutes, and 15 minutes to 19 minutes, respectively. For these codes, it seems CMS has subtracted the time associated with "greet patient and gowning" (3 minutes) and "process films" (4 to 8 minutes). These two activities are exclusively provided by the radiologic technologist, because radiation is involved, and because only a radiologic technologist can appropriately process the films. CMS allows only one staff type, so by definition, there is only one technologist involved with these services. Therefore, the room is not available for use by other patients while the radiologic technologist is engaged in these activities. Furthermore, until all images are processed and reviewed for quality, the patient does not leave the radiography room. It is clinical misunderstandings like this that emphasize the need for CMS to work more closely with physician stakeholders, such as specialty societies and the RUC, before unilaterally refining PE inputs. We request that CMS assign the entire technologist time associated with the two activities mentioned above as part of the room time.

We note additional technical errors as follows:

- At the top of page 73240: Code 72110 is not indicated for CMS codes ED025, EL012, and ER029.
- At the bottom of page 73240: A code is missing starting with CMS code EL012 to include top two rows on top of page 73241. Please clarify the correct code that should have been listed so that we may review and comment.
- On page 73241: The wrong code (i.e., 72170) is listed. Please clarify the correct code that should have been listed so that we may review and comment.

We request CMS make these technical corrections immediately to assure proper payment for these procedures in 2012.

Computed Tomography Angiography Codes

72191 (Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing)

74175 (Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing)

74174 (Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing)

- For code 74174,
    - CT room time should be 121 minutes and not 57 minutes. We disagree with the assigned room times for each of these codes. For 74174, it seems CMS has subtracted the time associated with “greet patient and gowning” and “process films” along with time associated with other clinical activities. These two activities along with other activities are exclusively provided by the CT technologist as radiation is involved and only a CT technologist can appropriately process the films. As with other imaging studies, patients do not exit the exam room until the technologist is assured the examination is of adequate technical quality, and this time must be included in the room time calculation. Furthermore, CMS only allows one staff type, so only one CT technologist is involved with these services. Therefore, the room is not available for use by other patients while the CT technologist is engaged in these activities. We request that CMS include the technologist time associated with the two activities mentioned above, as well as time associated with other clinical activities, as part of the CT room time calculation.
    - Staff type for all activities should be CT technologist (CMS code L046A)

- For code 72191,
    - CT room time should be 107 minutes and not 40 minutes. We disagree with the assigned room times for each of these codes. For code 72191, it seems CMS has subtracted the time associated with “greet patient and gowning” and “process films” along with time associated with other

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clinical activities. These two activities along with other activities are provided by the CT technologist as radiation is involved and only a CT technologist can appropriately process the films. As with other imaging studies, patients do not exit the exam room until the CT technologist is assured the examination is of adequate technical quality, and therefore, the time associated with film processing must be included in the room time calculation. Furthermore, CMS allows only a single staff type, so there is only one CT technologist responsible for these activities. Therefore, the room is not available for use by other patients. We request that CMS include the CT technologist time associated with the two activities mentioned above, as well as time associated with other clinical activities, as part of the CT room time calculation.

- Staff type for all activities should be CT technologist (CMS code L046A)

- For code 74175,
  - CT room should be 112 minutes and not 40 minutes. We disagree with the assigned room times for each of these codes. We believe the room times should be changed from 40 minutes to 112 minutes. For this code, it seems CMS has subtracted the time associated with "greet patient and gowning" and "process films" along with time associated with other clinical activities. These two activities along with other activities are exclusively provided by the CT technologist, as radiation is involved and only a CT technologist can appropriately process the films. CMS allows only a single staff type, so there is only one CT technologist involved with these services and therefore, the room is not available for use by the other patients. We request that CMS consider assigning the CT technologist time associated with the two activities mentioned above, as well as time associated with other clinical activities, as part of the CT room time calculation.
  - Staff type should be CT technologist for all activities (CMS code L046A)

- For codes 72191 and 74175, we ask that CMS provide a detailed explanation for room time, as we cannot duplicate the calculation. We believe CMS has arbitrarily removed a number of activities for each code that should be applied to the room time and, until CMS provides a better rationale, we believe CMS should restore the original PE RVUs for these services as a technical correction.

Hepatobilliary codes

78226 (Hepatobiliary system imaging, including gallbladder when present)

78227 (Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed)

The ACR is in full support of the following comments regarding these codes that were submitted by the Society of Nuclear Medicine.

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- **Gamma camera system, single-dual head** - CMS modified time inputs for 7 line items for the family of hepatobiliary imaging CPT 78226 and 78227. We disagree with those changes as noted below. Of those lines, the RUC approved adding lines, 12 +19+21+25+26+28 as necessary for the gamma camera. If CMS disagrees with those lines to add, they should clearly note why and give the reasoning for removal of any additional minutes above the added lines. Additionally, we would request CMS define which services specifically that were approved by the AMA RUC that CMS is removing any minutes to maintain transparency in the process. Given the inputs that CMS deleted or added we would have recalculated the times to be 83 minutes and 113 minutes respectively. Therefore, we do not understand nor agree with revising times to 75 and 107, as we are not clear what methodology would reach these equipment times. The societies stand by our RUC-approved times and equipment calculations.

- **Instruction/Counseling as patient is taken back to waiting area after each scanning session** - We strongly disagree with CMS decision to modify the time necessary to provide patient counseling; we believe CMS may be confusing this line item to standard instruction and counseling, standard for any procedure. For nuclear medicine procedures, typically our patients are radioactive when they leave our departments. There is additional time spent (in addition to standard instruction and counseling) with the patients at several points during the procedure and most important to state again when they are leaving the procedure. Additional discussion regarding airplane travel issues, avoidance of extended potential exposures to small children, such as grandchildren or others for a period of time due to radioactive materials is necessary, the time is important as patients often forget or have questions.

- **Prepare and position patient/ monitor patient/ set up IV** - IV set up for RPs is more extensive than traditional drugs to avoid contamination. Two minutes is not the standard time input for this activity. Is CMS confusing the input with prepare room, which does have a 2-minute standard?

- **Prepare room, equipment, supplies** - Nuclear Medicine collimators (different camera lenses for different procedures) are extensive to change and take time to change between patients. Room prep with positioning of camera and equipment is more than a standard room, which only requires a sheet, pillow etc. For nuclear medicine procedures we have standardized this to 3 minutes. We favor consistency between the NM procedures for this input with other RUC-approved procedures such as the Myocardial Perfusion Imaging (MPI) codes; we recommend this nuclear medicine specific standard of 3 minutes.

- **Provide pre-service education/obtain consent** - As noted in prepare room, equipment and supplies, we favor consistency between the NM procedures for this input with other RUC-approved procedures, such as the MPI codes, we recommend the standard of 3 minutes.

- **Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation** - The RUC has a long standing history of approving this

standardized NM line item to meet mandatory regulatory use of radiopharmaceuticals (RPs). We disagree with CMS revising this standard to 3 minutes. Moreover, CMS did not supply any detail to which activities from this line item they have removed. We disagree with the CMS decision and believe CMS should restore the five-minute standard, and further, CMS should clearly state any activities if they would recommend reduced minutes.

- **Specific room clean-up of RP injection areas with defacement of labels** - The RUC has a long-standing history of approving this standardized NM line item to clean up the room to meet mandatory regulatory use of RPs. We disagree with CMS revising this standard to 3 minutes. Moreover, CMS did not supply any detail to which activities from this line item they have removed. We disagree with the CMS decision, we believe CMS should restore the five-minute standard and, further, CMS should clearly state any activities if they would recommend reduced minutes.

Other Nuclear Medicine codes

78580 (Pulmonary perfusion imaging (eg, particulate))

78597 (Quantitative differential pulmonary perfusion, including imaging when performed)

78582 (Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging)

78598 (Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed)

78579 (Pulmonary ventilation imaging (eg, aerosol or gas))

- The time assigned for "computer workstation, nuclear pharmacy management (hardware and software) is off by 1 minute for each code and should be corrected for each of the 5 codes in the CMS PE database.
- The ACR notes that "Radioaerosol administration system" is not listed in CMS database for codes 78582, 78598, and 78579 although approved by the RUC. We request that CMS include this in the database.

We request CMS make these technical corrections immediately to assure proper payment for these procedures in 2012.

Percutaneous Biopsy Codes

47000 (Biopsy of liver, needle; percutaneous)

32405 (Biopsy, lung or mediastinum, percutaneous needle)

- CMS has assigned zero time for CT room for codes 47000 and 32405. The ACR strongly disagrees with the assignment of 0 minutes of CT room time and recommends that the RUC accepted CT room times be restored: 33 minutes for 47000 and 43 minutes for 32405. The room time should equal the service period activities accepted by the RUC, as the patient is in the room for the entirety of the procedure rendering the room unavailable for other services. CMS may be under

the false assumption that the CT room time is included with the supervision and interpretation (S&I) code 77012. However, 77012 only includes 9 minutes of CT time, the Practice Expense Advisory Committee (PEAC) standard for S&I codes, which are imaging related activities, such as "pulling old studies" and "image acquisition" [Reference – page 11 RUC Practice Expense Reference Manual]. Per the PE reference material, "The S&I code should receive a base time of 9 minutes for the room, and all other time will be allocated to the procedure code." During the recent PE subcommittee review, both the surgical and S&I codes were reviewed together to ensure that PE subcommittee standards were followed and no duplication occurred.

- The time for the "ECG, 3-channel (with SpO2, NIBP, temp, resp)" and "IV infusion pump" should be changed from 277 to 272 min for code 32405 and 268 to 252 min for code 47000 to stay consistent with RUC approved recommendations. In addition, the staff time for assist physician and monitor conscious sedation should be changed from 35 to 30 minutes for code 32405 and from 26 to 20 minutes for code 47000.

We request CMS make these technical corrections immediately to assure proper payment for these procedures in 2012.

IVC Filter codes

37191 (Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed)

37192 (Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed)

37193 (Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed)

The ACR requests that sterile gloves and sterile surgical gown should be changed from 4 to 2 pairs for all three codes.

We request CMS make this technical correction immediately to assure proper payment for these procedures in 2012.

Renal Angiography codes

36251 (Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent

recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral)

36252 (Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral)

36253 (Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral)

36254 (Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral)

For these four codes, we noted that CMS decreased the "Greet patient, provide gowning, assure appropriate medical records are available" from 5 to 3 minutes. CMS indicated that 3 minutes is the standardized time input. The ACR recommends that CMS add back the 2 minutes, as we were able to justify the 5 minutes to the RUC. The RUC has allowed a time other than the standard if the specialty is able to provide a rationale, which we did and again 5 minutes was accepted by the RUC as appropriate for these procedures.

<u>We request CMS make this technical correction immediately to assure proper payment for these procedures in 2012.</u>

<u>CT Head</u>

For code 70470 (Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections), we request CMS restore the CT room time from 30 min to 42 min. We disagree with the assigned room times for these codes. For this code, it seems CMS has subtracted the time associated with "greet patient and gowning" and "process films" along with some other unexplained technologist activity. These activities are exclusively provided by the CT technologist as radiation is involved and only a CT technologist can appropriately process the films. As with other imaging studies, patients do not exit the exam room until the CT technologist is assured the examination is of adequate technical quality and, therefore, time associated with film processing must be included in the room time calculation. Furthermore, CMS allows only a single staff type, so there is only one CT technologist involved with these services. Therefore, the room is not available for use by the other patients while the CT

technologist is engaged in these activities. We request that CMS assign the CT technologist time associated with the two activities mentioned above, as well as the other clinical activity, as part of the CT room time calculation.

X-ray foot and x-ray shoulder

- For codes 73030 (Radiologic examination, shoulder; complete, minimum of 2 views) and 73620 (Radiologic examination, foot; 2 views), we request CMS to change the basic room time from 11 min back to 14 min. We disagree with the assigned room times for these codes. For this code, it seems CMS has subtracted the time associated with either "greet patient and gowning" or "process films." These two activities are exclusively provided by the radiologic technologist, as radiation is involved and only a radiologic technologist can appropriately process the films. As with other imaging studies, patients do not exit the exam room until the radiologic technologist is assured the examination is of adequate technical quality and therefore time associated with film processing must be included in the room time calculation. Furthermore, CMS allows only one staff type so there is only one radiologic technologist involved with these services. Therefore, the room is not available for use by the other patients while the radiologic technologist is engaged in these activities. We request that CMS assign the technologist time of 14 minutes as the room time.

We request CMS make this technical correction immediately to assure proper payment for these procedures in 2012.

Abdominal Paracentesis

49083 (Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance)

- For code 49083, we request that CMS restore the assist physician time from 20 minutes to the 25 minutes approved by the RUC.
- We also request that ultrasound room time be changed from 39 min to 70 minutes to reflect the time the room is being used for the entire procedure and unavailable for other examinations.
- We also disagree with CMS removing the processor chemicals. This should be maintained as the PEAC-accepted picture archiving and communication system (PACS) surrogate.
- Lastly, the times associated with the various pieces of equipment should all reflect the total room time as modified above:
  - the Mayo stand should be 70 minutes
  - the table, power and ECG should be 80 min
  - the film alternator should be 70 minutes

We request CMS make this technical correction immediately to assure proper payment for these procedures in 2012.

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Kyphoplasty

22523 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic

22524 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar)

22525 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

- For codes 22523 and 22524, there is an error in the time assigned to the table. Instead of 60 minutes, it should be 240 minutes added to the procedure time. The 240 minutes is to account for the 4 hours associated with the conscious sedation.
- For code 22525, the RUC approved 70 minutes for rad tech, 40 minutes RN and 10 minutes for blend and submitted these recommendations to CMS. However, in the PE database, the times are listed as 12 minutes for rad tech, 70 minutes of RN, and 40 minutes for blend. CMS also changed “prepare room, equipment, supplies” from 2 to 0 minutes. We request that CMS reconsider the 2 minutes as approved by the RUC. These two minutes allow the time needed for the gathering of supplies needed to provide this service.

We request CMS make these technical corrections immediately to assure proper payment for these procedures in 2012.

Vascular codes

36200 (Introduction of catheter, aorta)
36245 (Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family)
36246 (Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family)
36247 (Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family)

The ACR is concerned with the process which CMS made changes to the staff time in addition to time associated with equipment. These changes were made outside of the RUC/PEAC and the CMS process and should have been sent to the RUC/PEAC for

comment by the specialty or proposed in the MPFS proposed rule for comment. We request that CMS work with the specialties through the RUC process to finalize these direct practice expense inputs. The ACR is also concerned with the time allocated to the equipment. We request that this issue be sent to the RUC/PEAC for further discussion and review with stakeholders.

In conclusion, the discussion above should serve as a reminder to CMS of the importance of maintaining accurate information in the CMS PE Database. Any refinements should follow established PEAC/PE Subcommittee standards. As we have brought to your attention in this and previous comments, there seem to be ongoing inaccuracies in information contained within the CMS PE database and inconsistencies in how the information contained in the database is used and maintained. This is a serious issue that the Agency should address immediately, as this database contains information that is vitally important to the provision of accurate practice expense calculations. Furthermore, despite the cryptic nature of the methodology, CMS payments are considered by many payers to reflect accurate payment policy, and are used in calculations of physician payments by many other payers. Therefore, we urge CMS to work with the RUC and other physician stakeholders to assure the inputs in the database are as accurate as possible and that CMS understands how the inputs are applied to the PE methodology. This will assure accurate use of resources, especially high cost and high maintenance imaging equipment. Otherwise, inaccurate payment policy will be inadvertently promulgated across all payers.

Of critical importance to the ACR is the proper assignment of room time for diagnostic imaging procedures. These changes in CMS assumptions, which we describe above and which at this point are entirely unexplained to stakeholders, represent a distinct departure from the historical PE assumptions made and reaffirmed by the RUC and its practice expense subcommittee. The application of these new CMS assumptions to recently revised services has led to rank order anomalies within certain families of codes. It appears that CMS is no longer mindful of the long-accepted standard that room time includes all of the time that the room is unavailable for use by another patient. In fact, in an April 26, 2010 correspondence between the AMA and CMS staff, the following was indicated by CMS: "Equipment time is the sum of specific line item activities on the PE worksheet where a labor category is using the piece of equipment, plus any additional time the piece of equipment is not available for use with another patient due to its use during the procedure in question." This is the guidance we have followed. Thus, room time should include all of the service time for the technologist assigned to that exam, as the room is unavailable during the same time the technologist is unavailable. Specifically, eliminating room time for "gown and greet patient by the technologist," "process films" and as yet unspecified technologists activities that prevent the room from being available for another patient are inconsistent with clinical practice and significantly underestimate the resources required to provide the services. The RUC has repeatedly affirmed this position in its recommendations that it makes to CMS.

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The additional reductions CMS makes in room time are especially troubling with the recent legislative increase in the equipment usage assumption to 75 percent. This leaves little available down time for any clinical activity related to the examination to occur outside of the room. In our opinion, in addition to being inconsistent with clinical practice, the current changes to room time calculations actually reflect "duplicate" reductions.

Additionally, CMS should consider that by producing further technical component payment reductions by arbitrary manipulation of direct PE inputs, CMS has further widened the gap between the Hospital Outpatient Prospective Payment System (HOPPS) ambulatory payment classification (APC) payments and the MPFS TC payments. As you know, the HOPPS APC payments are based on actual cost data from hospitals that are furnishing the identical services that physicians are providing in their offices and imaging centers. Physicians and Independent Diagnostic Testing Facility (IDTF) providers have to pay the same supply costs and clinical labor rates as hospital facilities. Furthermore, our analysis indicates the capital costs of hospital imaging equipment are accounted for elsewhere in hospital payments, so the HOPPS APC payment is almost entirely based on clinical labor and supplies, which are routinely updated positively as part of the HOPPS methodology to reflect the increasing costs of providing these services. Reductions in payments by arbitrary and specious manipulation of the PE inputs and methodology in the MPFS to reduce payments for capital costs to physician offices further widens the already inappropriate gap between hospital payments and physician office payments and will eventually drive patients to the more expensive hospital facilities as physician owned facilities and IDTFs are forced to close. As we have stated previously, we are particularly worried that beneficiaries' access to life saving diagnostic imaging services will become extremely limited in rural areas.

Finally, we believe that there is either a lack of sufficient institutional knowledge and/or inaccurate knowledge of clinical practice at the Agency leading CMS staff to make unilateral changes to the PE database that translate into unintended reductions in payment. We continue our willingness to work with the Agency on this as well as other important practice expense issues.

Physician Quality Reporting System

Quality Measures

We understand that the proposed radiology measures group (American Board of Radiology/American Board of Medical Specialties/American College of Radiology/Physician Consortium for Performance Improvement Radiation Dose Optimization measures) was withdrawn by the measure developer and, thus, not finalized. We are working with the measure developer to finalize the radiology measures for potential inclusion in PQRS 2013 and encourage CMS to relook at those measures during the upcoming rulemaking process. These measures are included in the Measures under Consideration for CY2012 Rulemaking. We urge CMS to include the measures to be reportable both as a measures group and as individual measures. Making any newly

proposed radiology measures available as individual measures would enable many more radiologists to registry report.

Maintenance of Certification Program Incentive

We appreciate CMS finalizing a more flexible approach to the interpretation of what is meant by "more frequent" participation in a Maintenance of Certification (MOC) program to qualify for the program .05 percent incentive. Specifically, that a physician participates more frequently than required by an MOC program in any one of the four elements, as well as completing a practice assessment every year (which includes a patient experience survey).

Interim Feedback Reports

We also appreciate CMS finalizing the proposal to provide interim feedback reports for claims-based reporting for 2012 and beyond. This is a much-needed tool that will enable successful reporting. We urge CMS to provide an opportunity for input on the form and content of the reports in the future to make them as useful as possible to participants.

Physician Compare Website

With respect to the Physician Compare website, we appreciate CMS' awareness of concerns over accuracy of information and your intention to: 1) conduct regular data refreshes to update information; 2) provide educational materials to physicians on maintaining an updated profile in the PECOS system; 3) develop and implement processes to ensure that data made public are statistically valid, reliable, and accurate; 4) consider creation of a "disclaimer" type page to note potential issues with accuracy and to avoid any misinterpretation of data; and 5) work with providers towards these aims. The ACR would welcome the opportunity to work with CMS on reviewing draft website disclaimers or participate in focus groups to ensure that the information on the Physician Compare website is accurate, and not subject to misinterpretation.

Physician Feedback Program

We agree with numerous comments in the Final Rule that many physician specialties do not have measures relevant to their practices appropriate for calculating a quality composite score. As we have stated previously, physician collaboration in developing valid and meaningful measurements and feedback reports for consultant or hospital-based specialties such as radiology, pathology, anesthesiology, and infectious disease is particularly essential. Attribution to these physician types in the current or planned structure and focus of the reports does not make sense. Since most services performed by radiologists and imaging providers are ordered by other health care providers on behalf of their patients, CMS must carefully consider how to attribute costs to radiologists. Radiologists cannot always control utilization, but they do routinely make decisions about the appropriateness of tests and their subsequent utilization for specific patients. Measuring this contribution is difficult since tests not performed are, by definition, never seen by the Medicare program. We appreciate CMS' plans to work with stakeholders to develop appropriate measures. The ACR welcomes an opportunity to work with CMS in this effort.

Conclusion

Thank you for the opportunity to comment on the interim values assigned to certain radiology codes and other vitally important issues in this Final Rule. We are hopeful that our input will lead CMS to better understand the resources and physician effort involved in radiology codes. We hope to be a resource to you to help further this understanding. If you have any questions about our comments please feel free to contact Maurine Dennis at 800-227-5463 ext. 4559 or via email at msdennis@acr.org.

Respectfully Submitted,

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