



March 24, 2006

Terry Kay
Deputy Director, Hospital & Ambulatory Policy Group
Centers for Medicare and Medicaid Services
Mail Stop C4-01-26
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Practice Expense Methodological Issues under the Medicare Physician Fee Schedule

Dear Mr. Kay:

The American College of Radiology (ACR), representing over 32,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments on practice expense methodological issues under the Medicare Physician Fee Schedule (MFS) as discussed at Medicare's most recent Practice Expense Town Hall meeting on February 15, 2006.

The ACR thanks the Centers for Medicare and Medicaid Services (CMS) for taking the initiative to hold the Practice Expense Town Hall meeting to provide clarification and discussion on practice expense methodological issues in determining resource-based practice expense relative value units. The ACR appreciates CMS' willingness to accept preliminary comments and to work with specialties to find solutions to these issues prior to publication of the Calendar Year (CY) 2007 MFS proposed rule. However, the ACR is concerned that the multiplicity of options presented at the Town Hall meeting may introduce too many variables at once and thus complicate an already complex process, making it difficult for future analysis to detect appropriate elements that may need modification. As such, **the ACR recommends that CMS reconsider its current approach to a new methodology and entertain the possibility of using the existing methodology with the only changes being the incorporation of Practice Expense Advisory Committee (PEAC) and supplemental survey data and the elimination of the non-physician work pool (NPWP). As noted later, however, the ACR believes that a careful assessment of the impact of all policy options, including this one, is essential in determining equitable adjustments in practice expense methodology.**

The ACR emphasizes the need to ensure that radiology procedures currently in the NPWP are accurately priced as they are converted to resource-based practice expense. Accordingly, before CMS dissolves the NPWP, **the ACR considers it essential that CMS incorporate the PEAC data as well as the accepted supplemental survey data to accurately price radiology codes in the NPWP.**

Practice Expense Advisory Committee (PEAC) Data

The ACR commends PEAC for their accomplishment in the refinement of Clinical Practice Expert Panel (CPEP) data for all CPT® codes from 1999 to 2004. The ACR dedicated a significant amount of physician volunteer time and staff time to provide PEAC with accurate direct practice expense data for all

radiology and radiation oncology codes. Along with the direct practice expense (i.e., clinical labor time, medical supplies and medical equipment used to provide the service) for each radiology code, the ACR also took into consideration the direct practice expense for other codes within the same family as well as codes outside the family. Accordingly, there is a high level of granularity and the PEAC data provide comparability and relativity across the entire range of CPT codes for all specialties. Therefore, the ACR believes that the PEAC data are the most current and accurate data to determine the expenses incurred by physicians in providing services and in calculating resource-based payments under the Medicare Physician Fee Schedule. These data are a much more accurate representation of resources required to perform radiology and radiation oncology procedures than hospital outpatient data or any other data from other payment systems.

Supplemental Survey

The ACR requests that CMS use ACR's radiology supplemental survey data for 2007 which has been accepted by the Lewin Group and Medicare. The ACR invested significant financial resources and dedicated considerable staff time as well as physician volunteer time toward the submission of the supplemental survey data. The ACR followed strict guidelines outlined by CMS and used an approved contractor to develop, conduct, collect and submit the data in the time frame defined by CMS.

Every specialty was given the opportunity to conduct the supplemental survey. CMS even extended the deadline twice in the rule-making process to provide all specialties the opportunity to submit practice expense supplemental survey data. CMS should not ignore its statutory guidance or its own administrative processes by failing to incorporate these data in 2007.

The ACR appreciates CMS' initial willingness to work with specialties to determine how to handle the practice expense data collected through the supplemental survey. The ACR is available to discuss this further and looks forward to working closely with CMS to have its data incorporated into the 2007 MFS. **The ACR strongly recommends that CMS use the accepted supplemental survey data for the CY 2007 practice expense values.**

Multi-Specialty Practice Expense Survey

For the future, the ACR agrees that there is a need for CMS to implement a survey process to update existing practice expense data. This process should occur at regular intervals and involve all specialties, using the same rigorous methodology required under the supplemental survey process. When the time comes to conduct a multi-specialty practice expense survey, the ACR requests that the survey instrument allow for the collection of practice level data and that any data obtained be blended with the specialty society supplemental survey data. In the meantime, the ACR supplemental survey data remains the most up-to-date and accurate practice expense data for radiology. **The process of conducting a multi-specialty survey should not delay the incorporation of the currently available supplemental survey data, especially since these data have already been accepted as valid by CMS.**

Equipment Utilization and Maintenance Costs

CMS assumes all equipment is used at 50 percent of capacity, and recognizes that this assumption was made without compelling data. Medicare Payment Advisory Commission (MedPAC) has recently made public a plan to collect utilization data in various US cities for Magnetic Resonance Imaging (MRI) and computed tomography (CT) equipment usage. The ACR urges CMS to be cautious in its efforts to

investigate equipment utilization rates. First, CMS must consider all medical equipment and not just the CT and MRI as MedPAC is doing in its study. Second, CMS must be cognizant of the typical practice. Urban practices will not be the same as rural practices, academic practices will not be the same as community practices, hospital-based practices will not be the same as free-standing or office practices and the typical practice may not be an average of the utilization rates obtained. Third, CMS should involve the specialty societies in their efforts to obtain these data. Therefore, in order for CMS to capture true equipment utilization for all equipment, the **ACR believes that CMS must 1) consider all equipment used in all practice settings for all specialties, 2) define the parameters that constitute a typical work day or week, and 3) involve the specialty societies in collecting any data necessary to create a more valid equipment utilization assumption.**

In addition, CMS should also take into consideration maintenance costs of equipment used. Maintenance contracts and upgrades vary greatly from one type of equipment to another. For example, maintenance contracts and upgrades for the higher technology equipment (i.e., CT, MR and PET) cost a higher percentage of total equipment costs to maintain than lower cost equipment (i.e., ultrasound, plain film). Therefore, CMS should allocate indirect costs for maintenance to reflect these different cost levels. We do not believe that the current methodology does so.

The ACR is available for further discussions and looks forward to working with CMS in determining the appropriate equipment utilization and maintenance costs for radiology procedures.

Practice Expense Methodology

At the Town Hall meeting, CMS discussed four potential practice expense methodologies. While the ACR is suggesting that CMS consider preserving the current top-down methodology at least until the transition from the NPWP is complete, we are also encouraged that not all the services in the NPWP are drastically reduced under the proposed 'bottom-up' methodologies.

How CMS weights the cost of equipment in determining the practice expense methodology has been of interest to the ACR. **Radiology is an equipment-intensive specialty with high equipment and equipment maintenance costs. These costs have been rising, and radiologists have little or no ability to control these cost increases.** Choosing a practice expense methodology that does not adequately weight equipment in the initial formula would seriously disadvantage equipment-intensive specialties, especially given other policy changes that could reduce equipment-related payments (e.g., changes in interest rate and equipment utilization assumptions). The ACR would like CMS to be mindful of this as they choose a practice expense methodology for the 2007 MFS proposed rule.

The ACR would very much appreciate if CMS would provide impact tables of proposed different methodologies as soon as possible for review and consideration by the specialties. **Specifically, the ACR would like to evaluate the impact of our suggestion to leave the current methodology in place while eliminating the NPWP, implementing the PEAC data and implementing the radiology supplemental survey data into the formula.** Also, the ACR encourages CMS to provide detailed analysis of the impacts of several different policy options (not just a single option selected by CMS) in the upcoming Notice of Proposed Rule for 2007 so that specialties can understand how key elements of each option affect their services.

The ACR's understanding of the four methods outlined in Table 4 at the Town Hall Meeting is that these methods were offered only as examples to demonstrate the impact of various determinants of three key questions: 1) what percentages of practice expense should be attributed to direct costs and to indirect costs? 2) what percentages of direct costs should be attributed to direct cost categories of clinical labor, supplies and equipment? and 3) how should indirect expenses be allocated? Realizing that CMS was not asking the medical community to choose one specific method as a preferred entity, the ACR believes that it is reasonable to maintain separate categories of direct and indirect practice expense prior to applying budget neutral adjustments. **If and when CMS moves away from the top-down methodology, the ACR believes the most appropriate methodology is likely to be one that uses:**

- **Socioeconomic Monitoring Survey (SMS) /supplemental survey data to determine the allocation of direct and indirect practice expense;**
- **Physician work and refined CPEP/PEAC data as weights to allocate indirect practice expense at the code level; and**
- **PEAC refined CPEP data to determine the percentages of labor, supply and equipment percentages of direct expense.**

Professional and Technical Component

In the MFS, radiology codes are broken out by professional component (PC), technical component (TC), and global (the sum of PC and TC). Indirect practice expense is captured both under the PC as well as TC. Since the indirect practice expense for the PC is not part of the NPWP, it should not be decreased in the process of moving the TC codes out of the NPWP. The analysis that CMS has provided of the four sample methodologies suggests that the practice expense relative value units (PERVUs) of the PC codes are not significantly impacted by removing the TC codes from the NPWP. **The ACR believes that CMS should reject any alternative methodology that negatively impacts the PERVUs for the PC codes.**

Impacts

Some specialties, including radiology, will be negatively impacted by the implementation of all of the practice expense changes combined with other factors under the MFS, including projected reductions in the conversion factor, five year review budget neutrality adjustments, Deficit Reduction Act provisions affecting imaging services, and the multiple procedure payment reduction for contiguous body parts. **The ACR recommends that CMS transition any change in practice expense methodology over a period of four years to lessen the impacts. The ACR also recommends that CMS place a limit on the impact on the practice expense payment changes to prevent access problems for Medicare beneficiaries.**

Conclusion

Thank you for the opportunity to comment on the various issues affecting practice expense under the MFS. The ACR hopes that the Agency will continue to work with specialties in order to determine a practice expense methodology that is workable for all specialties.

The ACR believes that the PEAC data and the supplemental survey data represent the best and most accurate cost data available to the Agency and should be the first priority for consideration.



The ACR looks forward to continued dialogue with CMS officials about the practice expense issues affecting radiology and radiation oncology. If you have any questions or comments on this letter or any other issues with respect to radiology and radiation oncology, please contact Angela Choe at 800-227-5463 ext. 4556 or via email at achoe@acr.org.

Respectfully Submitted,

A handwritten signature in black ink that reads "Harvey L. Neiman, MD". The signature is written in a cursive style.

Harvey L. Neiman, MD, FACR
Executive Director

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