

August 21, 2006

Mark McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1512-PN  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology; Proposed Notice**

Dear Dr. McClellan:

The American College of Radiology (ACR), representing over 32,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists is pleased to submit comments on the proposed notice "Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology" published in the Federal Register on June 29, 2006. We will address the proposed adjustment of work relative value units (RVUs) to preserve budget neutrality, the need for a transition to full implementation of the proposed work RVUs under the five-year review, the practice expense methodology, the excessive value reduction for some procedures, and the proposed work RVU for CPT® code 76075 Dual energy x-ray absorptiometry (DXA), bone density study.

**Budget Neutrality**

In the Regulatory Impact Analysis section of the proposed notice, the Centers for Medicare and Medicaid Services (CMS) estimates the impact of proposed changes in work RVUs resulting from the five-year review of physician work RVUs to be \$4 billion. Since section 1848(c)(2)(B)(ii) of the Omnibus Budget Reconciliation Act of 1989 requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than \$20 million from what the expenditures would have been in the absence of these changes, CMS must make adjustments to preserve budget neutrality. CMS describes the two options that were considered for making these adjustments:

Option 1: Reduce all work RVUs. CMS estimates that all work RVUs would have to be reduced by 10 percent to maintain budget neutrality under this option.

Option 2: Adjust the conversion factor (CF). CMS indicates this option would require an estimated 5 percent reduction in the CF to maintain budget neutrality.

The Agency's stated reason for choosing option 1 was a belief that it may be more equitable to apply the budget neutrality adjustment across services that have work RVUs. However, this is a dramatic departure from previous Five Year Review budget neutral adjustments, and the **ACR recommends that CMS apply the budget neutral adjustment required for the Five Year Review to the Conversion Factor rather than physician work.** We appreciate the opportunity to comment on this proposal.

Unlike the practice expense RVUs, where the methodology and data are undergoing substantial refinement, physician work RVUs have been stable for more than a decade and as such a separate budget neutral adjustment for work is not necessary. Applying the proposed budget neutral adjustment only to

work is no different than directly scaling the work RVUs. We believe adjusting the CF is the more appropriate option for maintaining budget neutrality. The RVU values we have today have withstood the test of time, and have been modified based on three Five Year Reviews. CMS and organized medicine have agreed that maintaining the integrity of the resource based relative value system (RBRVS) is important, and the conversion factor has been the method of choice when making adjustments to physician work. We acknowledge that a budget neutrality adjustment factor was applied to the work RVUs following the first five-year review in 1997, but we believe that CMS recognized the problems this would create since CMS specifically noted in the final rule implementing the first five-year review of relative values that:

“[i]n years subsequent to 1998, we plan to make the budget neutrality adjustments to the CFs [conversion factors]” (Federal Register, November 22, 1996, p. 59533).

And in 1999, the Agency stated:

“We did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUs to determine a payment amount that matched the amount actually paid by Medicare.” (*Federal Register*, Vol. 68, No. 216, Pg. 63246).

There is no reason to believe that this statement is not applicable today. Budget neutrality adjustments required by changes in work RVUs have been applied to the conversion factor since 1999, consistent with the agency’s commitment and the long-standing recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC). CMS provides no compelling argument in the Proposed Notice to justify changing this position.

While not applicable to the Medicare system, CMS should be cognizant that maintaining the stability of the work RVUs is essential since Medicare’s RVUs are used by many other payers. In addition, they are often the basis of physician compensation and productivity analyses. Merely publishing unadjusted work values in Addendum B, does not change the fact that CMS is proposing to scale the work values as a result of the Five Year Review, and while we understand it is not the intention of the Agency, by scaling the RVUs it makes it seem to outside observers that the physician work of the services unaffected by the Five Year Review has decreased as a result of the Five Year Review.

Eventually, we would like to see the conversion factor used to make budget neutrality adjustments for work, practice expense and professional liability insurance (PLI). However, development of practice expense RVUs is far from complete, and we recognize that a separate budget neutral adjustment for practice expense is mandatory until the RVUs are stabilized.

While Interventional Radiologists regularly provide clinical care to their patients and thus utilize E/M codes to a significant degree, the majority of radiologists represented by the ACR do not provide a significant amount of E/M services. Consequently, radiology as a specialty received relatively little benefit from the five-year review as E/M services are provided with a low overall frequency within the specialty on average. And while a budget neutral adjustment to the conversion factor can be explained to our members as part of the regulatory process, the concept of scaling the work RVUs has the effect of devaluing the professional work of our members. Obviously our specialty has a significant number of technical component services and we recognize that the currently proposed global and technical

component (TC) payments will be somewhat negatively impacted by our recommendation to place the budget neutrality adjustment for the Five Year Review on the conversion factor. Nonetheless, **for the reasons stated above and because appropriate recognition of the physician work in radiology services is vitally important to our profession, we urge CMS to make the budget neutrality adjustment to the conversion factor in the final rule.**

### **Transition for Five-Year Review**

As noted above, CMS estimates the impact of proposed changes in work RVUs resulting from the five-year review of physician work to be \$4 billion. This extraordinary impact is due largely to significant increases in the work RVUs for evaluation and management (E/M) services and the accompanying increases in the post-operative work RVUs for procedures with 10 or 90 day global periods. In this letter, we are not commenting on the proposed RVUs for these services. However, we note that for those specialties that typically do not provide E/M services or perform surgical procedures, the negative impact of the increases in work RVUs for these services will be significant and immediately effective on January 1, 2007.

In the section of the proposed notice dealing with the new practice expense methodology, CMS states “We are concerned that, when combined with a proposed negative update factor for CY 2007 and the proposed changes to the work RVUs under the five-year review, the shifts in some of the practice expense (PE) RVUs resulting from the immediate implementation of our proposals could potentially cause some disruption for medical practices. Therefore, we are proposing to transition the proposed PE changes over a four-year period.”

We support this transition and believe the same logic for a transition applies to the work RVUs. **Therefore, we recommend a transition of the work RVUs consistent with the transition CMS has proposed for the practice expense RVUs.** During the transition period, the work RVUs would be calculated on the basis of a blend of the work RVUs that result from the five-year review (weighted by 25 percent during CY 2007, 50 percent during CY 2008, 75 percent during CY 2009, and 100 percent thereafter), and the current CY 2006 work RVUs for each existing code. We see nothing in the statutory requirements for periodic review and adjustments in relative values found at section 1848(c)(2)(B) that would preclude the transition in work values that we are recommending here.

### **Practice Expense**

In the proposed notice, CMS states that its three major goals with respect to the resource-based practice expense (PE) methodology are: 1) to ensure the practice expense payments under the Medicare Physician Fee Schedule (MFS) reflect the relative resources required for each of the services; 2) to develop a payment system that is understandable so that specialties can better predict the impacts of changes in the practice expense data and 3) to stabilize the practice expense portion of the MFS so that changes in practice expense data does not produce large fluctuations. The ACR believes the practice expense methodology as explained in the proposed rule is not as transparent and understandable as CMS intended. We have two specific issues related to the methodology and a comment on the accuracy of the data used to calculate the PE RVUs that we would like to bring to your attention.

#### Physician Work in the Allocation of Indirect PE RVUs

As described in the proposed notice, the work RVUs that are used in the calculation of the indirect PE RVUs have been reduced by 10 percent as a result of the budget neutrality adjustment associated with the

five-year review. In using the scaled RVUs, this feature of the methodology has the effect of understating the indirect costs of services with physician work and results in a higher proportion of the PE RVUs for global services (i.e., those with both professional and technical components) being attributable to the technical component than would occur if the full work RVUs were used in the allocation of the indirect PE RVUs. We note that if the practice expense methodology was being revised in any year other than a five-year review year that this would not be an issue and the full work RVUs would be used in the allocation.

If our recommendation to make the budget neutrality adjustment to the conversion factor in the final rule is accepted, then the full work RVU will be used in the allocation of the indirect PE RVUs and this problem will be corrected. If CMS decides to finalize its proposal to make the budget neutrality adjustment to the work RVUs, then **the ACR requests that this feature of the methodology be revised so the true (unadjusted) work RVUs are used in the allocation of the indirect PE RVUs.**

#### Assumptions Used in Calculating Equipment Costs

In the proposed rule, CMS provides the formula used to calculate the direct practice expense costs associated with equipment. The formula is complex and takes account various factors, including the hours an office is open, the percent of the time the equipment is in use, the useful life of the equipment, the interest rate on the purchase of equipment and the cost of maintenance. The Medicare Payment Advisory Commission (MedPAC) has suggested that the current assumption that equipment is in use 50 percent of the time an office is open is too low and that the assumption of an 11 percent interest rate is too high. However, other factors such as maintenance costs may also be incorrect. For certain, all of these factors can vary depending on the equipment in question.

In the proposed rule, no proposals are made to revise the formula and comments are not sought on the issue. Consequently, we assume that no changes could be made in the final rule. However, it is possible that CMS will receive some specific recommendations for change in 2007. In the absence of specific CMS proposals for change, **the ACR requests that the acceptance of any recommendations be deferred pending the collection of valid data on all the important factors used in the calculation of equipment costs.** We agree with Herb Kuhn, the Director of the Center for Medicare Management who said in testimony before the House Subcommittee on Health of the Committee on Energy and Commerce on July 18, 2006 that “data to substantiate alternative equipment utilization assumptions are not available.” We are prepared to work with CMS in the months ahead to collect the necessary data and we look forward to the opportunity to comment on any proposed changes to the formula in a future Federal Register notice or proposed rule.

#### Practice Expense Per Hour (PE/hr) Figures

The ACR appreciates and applauds CMS’s proposal to accept the ACR supplemental survey data to calculate the practice expense values. However, the ACR remains concerned that CMS did not fully utilize the ACR supplemental survey data. The ACR is also concerned with weighting of the data. The ACR followed strict guidelines outlined by CMS and used an approved contractor, Doane Marketing Research, to submit the data. The ACR invested significant financial resources, staff time and physician volunteer time to complete the survey.

The ACR’s original supplemental survey data resulted in a practice expense per hour of \$194.82 as calculated by Doane, but through a series of steps the final value being used by CMS has fallen to \$174.20. This is well out of proportion to the adjustments for other specialty societies that conducted supplemental surveys over the same period as that for the ACR. One adjustment involves a reduction of

the original \$194.82 to \$185.72 by CMS's contractor, The Lewin Group. The difference is due to how total patient care hours are calculated. In the supplemental survey, Doane collected data on the number of full and part-time physicians in the practice and the total number of clinical patient care hours they provided in a typical week. The mean number of hours was approximately 21 per part-time physician, compared with approximately 37 per full-time physician. Doane used the complete survey data on both full-time and part-time physicians in obtaining an accurate sum of total hours for all physicians in the practice and thus, precise mean total expenses per hour.

In calculating total hours for all physicians in the practice, The Lewin Group chose not to use the complete set of acquired survey data, disregarding the survey data on part-time hours and, instead, imputed hours for part-time physicians by an incorrect methodological decision to assign full-time hours to all part-time physicians. Lewin's changes resulted in an increase in total hours for 47 percent of practices, a decrease for 4 percent of practices, and no change for 49 percent of practices. These changes also resulted in total annual hours for all physicians in the 171 practices surveyed being 220,907 higher by The Lewin Group's method, compared with the direct calculation by Doane. The higher hours used by The Lewin Group accounts for mean expenses per hour being lower (\$185.72) than that obtained by Doane (\$194.82). It violates sound statistical practice to discard valid data and substitute imputations based on incorrect suppositions. We have reviewed The Lewin Group's written justifications for its methods and strongly disagree with their rationale for inflating the physician hours. Despite The Lewin Group claim that the standard methodology is to allocate full-time hours to part-time physicians, The Lewin Group has, in at least one prior instance, used the complete data set and has allocated appropriate part-time hours to part-time physicians. Since precedent for our suggested methodology has been established by The Lewin Group and accepted by CMS, **the ACR requests that CMS implement the full set of data from the ACR supplemental survey as accurately analyzed by Doane Marketing Research.**

Another adjustment involves weighting the data, which further devalued the figure from \$185.72 to \$159.42. There was no transparency in this process, particularly in regard to sampling stratification, and the ACR would greatly appreciate having the opportunity to examine and comment on the methods used by The Lewin Group and adopted by CMS.

We look forward to working closely with CMS to ensure appropriate practice expense per hour for radiology procedures. In developing final policies, we believe that CMS must ensure that no errors have been made in computing the PE/hr value for radiology.

#### Accuracy of the Data

Based on a briefing on the proposed notice that was provided by CMS staff at the offices of the American Medical Association after publication of the proposed notice, it is our understanding that there may have been errors in the PE/hr data for some specialties that did not submit supplemental PE data. If that is the case, it is possible that the PE RVUs published in the proposed notice are not correct. We believe it is incumbent on CMS to identify and correct any errors as soon as possible and **the ACR asks that CMS be willing to accept additional comments from the ACR and any other interested parties after the close of the comment period if it turns out that corrected RVUs are significantly different from those that were published in the proposed notice.**

#### Impact on Practice Expense Values

The ACR believes the practice expense methodology as explained in the proposed rule is not as transparent and understandable as CMS intended. When comparing the 2006 practice expense values to

the proposed 2007 and to the proposed fully transitioned 2010 values, the ACR discovered a wide range of reductions and increases for radiology codes. While some of these codes are infrequently used, there are many frequently used services that are significantly reduced in value, to the point where physicians may find it untenable to continue providing those services, resulting in a negative impact on access to care for Medicare beneficiaries. Examples include services such as DXA, CAD mammography, stereotactic breast biopsy, interventional, nuclear medicine and certain radiation oncology procedures. **The ACR strongly believes that the new practice expense methodology used should provide more consistent RVU assignment across all radiology procedure codes, particularly those that have unique characteristics, such as medical physics.** We note that the two medical physics TC only codes will be adversely impacted by the proposed changes. These reductions (-68.9% for 77336 and -32.6% for 77370) are, we believe, an unintended consequence of the revised methodology. These codes from the non-physician work pool have no equipment cost and suffer significantly from the new methodology. Such a large decrease in value will impair adequate funding for the safe and effective delivery of radiation therapy services to cancer patients. **We urge CMS to review the factors that have caused this devaluation.**

Of additional concern to the ACR is the striking variability of RVU changes among procedures in the same family. It seems illogical that unilateral and bilateral diagnostic mammography would experience a much needed, and generally agreed appropriate, increase in value while screening mammography would experience a decrease. **The ACR is very concerned with this wide range of variability in practice expense values in all modalities and seeks explanation and additional information from CMS.** If, upon further analysis, we find the need to modify PE inputs, we will bring them to the Practice Expense Review Committee (PERC) and request the agency to consider correcting the inputs ahead of any scheduled review of practice expense data.

#### Assignment of Equipment Room Time for Interventional Imaging Services

The ACR is concerned that the equipment room time assigned to interventional radiology services (i.e., 74XXX and 75XXX codes) may not be appropriate. **The ACR recommends CMS revisit the method used to determine the equipment room time for these services to ensure accuracy.** The ACR supports comments submitted by Society of Interventional Radiology (SIR) on this issue and **encourages CMS to work with the ACR and SIR on this issue to get it corrected before the final rule is implemented.**

#### **Medical Physicist Salary**

The American Association of Physicists in Medicine (AAPM) conducted a survey on Medical Physicist salary. The current hourly wage of a Medical Physicist may not be accurate as CMS based it on the Department of Labor data for a health physicist and not a medical physicist. Accordingly, **the ACR recommends that CMS base hourly wage of a Medical Physicist on the 2005 AAPM Salary data with an inflation adjustment for 2006.** The total income for a Medical Physicist averaged at \$152,100 in 2005. This amount included consulting fees, but no benefits.

#### **Discussion of Comments - Radiology, Pathology, and Other Misc. Services**

As part of the five-year review process, CMS referred 24 codes in the radiology section of CPT to the RUC. These codes are listed in Table 27 of the proposed notice. The RUC recommended that the current work RVUs be maintained for 21 of the 24 codes. The ACR appreciates the CMS decision to accept the RUC recommendations for all but 3 of these codes. Two of the codes for which the RUC

recommendations were not accepted are provided primarily by cardiologists (78478 and 78480) and will not be addressed in these comments. The third code is 76075 [Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)]. CMS proposes to accept the RUC recommendation that the work RVU be decreased from 0.30 to 0.20.

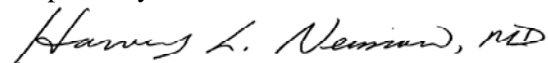
At the beginning of the five-year review process, the ACR was the only specialty to express interest in conducting a survey for this code. As a result, other specialty societies that provide DXA, such as internal medicine, rheumatology and family practice did not participate in the survey. In addition, other organizations that are not part of the RUC process such as the International Society of Clinical Densitometry have members who also perform DXA. We understand that some of these specialty societies and organizations may be submitting comments on the proposed notice requesting that the work RVUs be restored to the current level of 0.30.

CMS in the past has stated that it wants to ensure that all stakeholders are represented in the determination of physician work. **The ACR encourages CMS to consider any comments from any of the other specialty societies and organizations performing DXA so that their views may be taken into account in the determination of the final work RVUs for 2007.** If CMS decides to include this code on the agenda for a refinement panel, the ACR would appreciate the opportunity to participate.

### **Conclusion**

Thank you for the opportunity to comment on this proposed notice. The ACR encourages CMS to continue to work with physicians and their professional societies in order to create a stable and equitable resource-based payment system. The ACR looks forward to continued dialogues with CMS officials about these and other issues affecting radiology. If you have any questions or comments on this letter or any other issues with respect to radiology, please contact Angela Choe at 800-227-5463 ext. 4556 or via email at [achoe@acr.org](mailto:achoe@acr.org).

Respectfully Submitted,



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