



December 29, 2006

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Service
Department of Health and Human Services
Attention: CMS-1321-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007

Dear Ms. Norwalk:

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 “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007” Final Rule published in the Federal Register on December 1, 2006. In our comments, the ACR will focus on the following issues in the final rule:

- Budget neutrality adjustment to the physician work values
- Delay in implementation of proposals on the reassignment rule
- Practice expense
- Imaging procedures affected by the Deficit Reduction Act (DRA)
- Geographic practice cost indices

Budget Neutrality

The ACR is very disappointed and remains concerned that the Centers for Medicare and Medicaid Services (CMS) decided to apply the budget neutrality adjustment required for the Five Year Review to the physician work, as this is a dramatic departure from previous Five Year Review budget neutrality adjustments. The CMS decision is contrary to the views of the medical community that were expressed in numerous comments, including those from the ACR, the American Medical Association (AMA) and the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The vast majority of professional societies whose members treat Medicare beneficiaries recommended that the budget neutrality adjustment be made to the conversion factor and not to the physician work values. 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 RUC.

The ACR believes that being consistent with previous adjustments to the conversion factor is a more fair and equitable application of budget neutrality adjustments. The ACR is opposed to the CMS decision because it places a disproportionate burden on hospital-based physicians whose compensation for medical services is derived only from the professional component (PC) and is thus heavily dependent on the work RVU.

In addition, CMS should be cognizant that maintaining the stability of the work RVUs is essential since Medicare's RVUs are used by many other payers. 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. 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.

The ACR strongly recommends that CMS reconsider applying the budget neutrality adjustment to the conversion factor and not to the physician work RVU.

Reassignment Rule and Physician Self-Referral

In its comments on the Proposed Rule, the ACR offered strong support for the proposed amendments to the reassignment provisions at §424.80, as well as for the adoption of further amendments to §424.80(d) that CMS is considering. The ACR again strongly recommends that diagnostic tests in the Designated Health Services (DHS) category of radiology and certain other imaging procedures should not be excepted from those amendments. The ACR again recommends that an anti-markup provision should also apply to the reassignment of the professional component (PC) of diagnostic tests performed under a contractual arrangement and again suggests that CMS consider a larger and more appropriate minimal square footage in the Stark II regulatory definition of "centralized building" for radiology and certain other imaging procedures.

The ACR is disappointed that CMS has decided to "study the issue further and issue final regulations in the near future." The ACR is particularly concerned that CMS indicated it delayed issuing final regulations because implementing these proposals might limit the ability of some group practice arrangements to "enable Medicare beneficiaries to have the convenience of receiving medical services at one location."

The ACR believes that group practice arrangements that advocate and perpetuate self-referral improperly use the rationale of "patient convenience" to justify the need for self-referral. If, at the time of an office visit, the patient needs a urinalysis, blood count, or EKG, these tests can be done immediately and greatly enhance patient convenience. However, if the patient needs a CT, MRI, or PET scan, there are several factors that make it improbable, if not impossible, for the test to be done at the same visit, thus negating

any “convenience of receiving medical services at one location.” From a clinical perspective, CT, MRI, and PET all require some degree of patient preparation, including bowel opacification and fasting prior to contrast injection. Many times, the imaging equipment owned by the self-referring practice is at an entirely different location from the physician’s office. Additionally, scheduling conflicts in a busy self-referring practice may make it difficult for patients to receive these examinations on the same day as their office visit. Therefore, for the vast majority of patient office visits, any necessary CT, MRI, or PET scans are scheduled at a different time. In fact, the patient's convenience could actually be enhanced if the hospital’s or radiologist’s imaging facility were nearer their home than the office of the self-referring group practice arrangement.

The ACR strongly urges CMS to adopt its proposed changes to the reassignment rules through final regulations in the near future. The ACR is willing to work closely with CMS to further define how changes to the reassignment rules can further reduce inappropriate imaging referral practices and also provide better care for patients.

Practice Expense

The ACR appreciates CMS accepting its comments to run the practice expense methodology independently from the Five Year Review budget neutrality step.

The ACR continues to be concerned with the practice expense rate per physician hour for radiology and how that rate was calculated by the Lewin Group. In addition to the additional part-time hours that were added to the formula, the ACR is concerned that there are calculation errors similar to those that took place in the calculations of the radiation oncology PE/hr rate.

The ACR would like to work with CMS in the coming year to address this issue and explore its further resolution to achieve a more accurate PE/hr for radiology.

Deficit Reduction Act: Reduction in TC for Imaging Services Under the PFS to OPD Payment Amount and Payment for Multiple Imaging Procedures for 2007

The ACR appreciates CMS applying the multiple procedural reduction prior to the DRA cap for the 2007 Medicare Physician Fee Schedule (MPFS) payments. Applying this step prior to the DRA comparison mitigates the “double hit” that was of concern to ACR. We very much appreciate your consideration of the data and arguments ACR presented within the past year. The ACR also appreciates CMS’ careful consideration of ACR’s data and the decision not to raise the reduction to 50 percent for 2007. However, since the Ambulatory Payment Classification (APC) payment inherently accounts for the cost savings of contiguous imaging procedures, the ACR remains concerned that the 25 percent reduction for many contiguous imaging procedures, even if applied before the DRA comparison, will reduce payment below the APC level and thus result in an inappropriate level of reduced payment.

Exclusion of Carrier Priced Services

The ACR strongly disagrees with CMS' interpretation that the Deficit Reduction Act legislation applies to carrier priced services. Section 5102 of the DRA requires a comparison of the APC payment to the technical component (TC) payment established under the MPFS. However, since CMS has elected not to establish a technical component (TC) payment for PET and PET/CT under the MPFS, there is no comparison to be made. In addition, the statute requires the Secretary initially to determine whether the PFS amount for the imaging service exceeds the OPFS amount without regard to geographic adjustment. If it does, then the payment (based on the APC amount) is adjusted by the geographic adjustment factor. Since geographical adjustments are applied to services with established RVUs and not to carrier-priced services, we continue to believe that the DRA does not apply to carrier-priced services. With regard to Category III codes, there is an imbalance between the hospital outpatient prospective payment system (HOPPS) and the MPFS with respect to how these codes are handled. Category III codes are meant to be carrier priced while data on costs and indications are collected. The MPFS allows for this carrier independent data to be collected. However, Medicare chooses to place Category III codes in APCs under HOPPS. Setting a preliminary lower price on these procedures in hospital outpatient and thus the office setting establishes a troubling precedent on how their corresponding Category I codes might be valued in the future. This pricing effect on new technologies is inaccurate and inappropriate.

The ACR urges CMS to reconsider its apparent broadening of the intent of the DRA legislation and the negative effect that broadening will have on the well-established process of accumulating data to accurately value new technology.

Global Period for Remote Afterloading High Intensity Brachytherapy Global Procedures

The ACR appreciates CMS' decision to finalize its proposal to change the global period for codes 77781, 77782, 77783 and 77784 from a 90 day to XXX global period.

Geographic Practice Cost Indices (GPCI)

Although the current floor of 1.00 for the work GPCI will be extended one more year (under a provision of the Tax Relief and Health Care Act of 2006), the ACR remains concerned with the practice expense and malpractice GPCIs for Puerto Rico (and the work GPCI that would otherwise have applied absent the recent Congressional intervention), since low GPCI values make it difficult for physician practices in Puerto Rico to retain professional and technical staff, who are being recruited away by physician offices from locales with much higher GPCIs. The ACR understands that Medicare will be looking into the GPCI issues further this year and *encourages CMS to consider alternative data sources or ways to configure payment localities that would address the problem with the GPCI for Puerto Rico.*

Conclusion

Thank you for the opportunity to comment on this final rule. The ACR encourages CMS to continue to work with physicians and their professional societies. The ACR looks forward to a continuing dialogue 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.

Respectfully Submitted,



Harvey L. Neiman, MD, FACR
Executive Director

cc: Herb Kuhn, CMS
Ken Simon, MD, CMS
Carolyn Mullen, CMS
Pamela West, CMS
Rick Ensor, CMS
Ken Marsalek, CMS
John A. Patti, MD, FACR, Chair, ACR Commission on Economics
Bibb Allen, Jr., MD, FACR, Vice-Chair, ACR Commission on Economics
Pamela J. Kassing, ACR
Maurine Spillman-Dennis, ACR
Angela J. Choe, ACR