

Summary of the 2010 Medicare Physician Fee Schedule Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the review copy of the 2010 Medicare Physician Fee Schedule (MFS) final rule on October 30, 2009. The American College of Radiology (ACR) will submit comments to CMS by end of December. Following are the highlights of the final rule.

Equipment Utilization Rate

Proposed: Change the equipment utilization rate from the current 50 percent to 90 percent for equipment priced over 1 million dollars.

ACR comments: ACR stated that there is inadequate data to support a change in the utilization assumption for advanced diagnostic imaging and other high cost equipment. We said that the RBMA survey more accurately reflects the current equipment utilization for diagnostic imaging across a broad range of sites. Excluding the very small sample size for office-based interventional radiology equipment, the ACR stated that we support the RBMA data and would support an expansion of that survey for additional data collection.

Final rule: CMS will increase the equipment use rate to 90 percent for expense diagnostic equipment priced at more than \$1 million (CT and MR, but not for therapeutic equipment. CMS is providing a 4 year transition (25/75, 50/50, 75/25, 100/0) to the new practice expense values.

MedPAC supports CMS' proposal to increase the equipment utilization rate to 90 percent. CMS believes that with the MedPAC analysis along with the equipment rate data from the PPI survey, that they are using the best data currently available to increase the rate to 90 percent for MR and CT, consistent with the BBA requirement that they use actual data on equipment use rate. CMS agrees with MedPAC analysis and comment that decreasing the practice expense payment rate for expensive diagnostic imaging services should not affect access to care in rural areas.

CMS is open to receiving more comprehensive data than the responses of 16 RBMA members from the RBMA or from the public. CMS will evaluate all data submitted for consideration in future rulemaking.

Physician Practice Information Survey (PPIS)

Proposed: CMS proposed to use the new physician practice information survey data for radiology and other specialties. This new data would change the practice expense per hour (PE/HR) for radiology from the current \$204 to \$134.84, a drop of 34% in Medicare's practice expense formula.

ACR comments: The ACR recommended the following:

- CMS delay any implementation of the PPIS data and change to the radiology PE/HR until a complete analysis of the survey result can be performed;
- If CMS proceeds then to blend the final/revised PPIS results with the ACR SMS supplemental survey data;
- CMS continue its policy of avoiding drastic changes to payment rates and phase in changes to the practice expense RVUs over four years;

- CMS to place the relevant subspecialties of radiology (radiology, nuclear medicine and interventional radiology) into one practice expense category for the purposes of the practice expense cost surveys as many radiology practices provide a large spectrum of subspecialty care; and
- CMS allow access to PPIS data and disclose all formulas that are used for calculating the PE/HR and revised practice expense RVUs to insure transparency in this significant effort;
- The survey data is severely flawed for radiology and that the data should be required to meet the precision requirements the same as what was required for the radiology supplemental survey.

Final rule: CMS is finalizing their proposal to use the PPI survey data. However CMS will phase in the implementation over four years from the current practice expense data to the practice expense data developed using the new PPI survey data. This four year phase-in starts with 75% of current practice expense data and 25% of new data to be used to set the practice expense values for 2010. Then the mix will be 50%/50% in 2011, 25% old data and 75% new data for 2012 and 100% of new data for 2013.

The AMA Survey collected more than 7000 surveys for over 51 specialties, 3656 responses were used over 51 specialties – that’s an average of 71.68 responses per specialty.

CMS justifies that the PPIS data is a contemporaneous, consistently collected and comprehensive multispecialty survey and thus should be used for all specialties. CMS also does not believe precision requirements need to be met nor is proposing to establish them.

CMS is asking for comments regarding MedPAC’s suggestion that CMS consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on practice cost surveys. These comments and suggestions will be addressed in future rule-making.

Potentially Misvalued Services under the Physician Fee Schedule

Review of services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures

Proposed: CMS to analyze codes that are billed together 75 percent of the time, excluding E/M services. CMS to analyze both physician work and practice expense inputs. If duplication found, to consider MPPR or to bundle the services involved. In 2009, MedPAC requested that CMS consider duplicative physician work and practice expense in any expansion of the MPPR.

ACR comments: The ACR stated that the assumption that there is duplicative work accounted for when these combinations of services are performed is erroneous. Mentioned that we continue to believe in the merits of the component coding system and is convinced that creating bundled codes describing all image-guided services is problematic and too complex to be done without careful consideration and involvement of the CPT® Editorial Panel and the Relative Value Update Committee (RUC). Pointed out that the volume and complexity of creating and valuing new bundled codes

describing all possible procedures currently reported by component coding would be incredibly burdensome to the specialty societies.

The ACR cautioned in expanding this analysis to the 75 percent threshold as society resources could easily be stressed if this more relaxed screen results in new physician surveys for a large number of services.

If further MPPRs are considered, the ACR urged CMS to recognize that a 25 percent reduction has already been applied to the TC of certain diagnostic imaging services. This has occurred in addition to the payment limit for advanced imaging services enacted as part of the DRA with the result being as much as a 40 percent reduction in Medicare payments for advanced diagnostic imaging studies. The ACR stated that we are concerned that further reductions could limit Medicare beneficiary access to imaging services, particularly in the rural settings, where geographic practice cost index (GPCI) reductions are also proposed.

Final rule: CMS received comments supporting the 75 percent while other did not. Some folks said that CMS should rely on the work that is being done in this area by the AMA RUC. CMS stated that they will consider comments received as they explore the best way to address this issue. CMS looks forward to working with the AMA RUC to accurately assess these services.

Site of Service

Proposed: Make work RVU changes to several of the codes where the valuation had been adjusted to reflect changes in the site of service but the RVUs had not been extracted by the AMA RUC.

ACR comments: Recommended that such services be evaluated in total through established RUC mechanisms which may require re-survey. While CMS proposes to maintain RUC-recommended values until a methodology is developed to address codes that result in negative valuation when the CMS methodology is used, it proposes to adopt the agency's re-calculated values for other services. Instead, the ACR indicated that CMS should accept the RUC-recommended values and not make changes that risk disrupting the careful relative valuation of the affected services. If CMS is unwilling to accept the RUC values, the ACR recommended that CMS simply retain the current values until the RUC has been given an opportunity to re-examine the values and perhaps develop a more complete and persuasive rationale for its recommendations.

Final rule: CMS is not finalizing their proposal to change the work RVUs for codes with site of service anomalies that were included in Table 8 of the proposed rule. CMS is accepting the AMA RUC recommended work RVUs in the interim and request that the AMA RUC utilize the building block methodology to revalue the services listed in Table 4.

AMA RUC Review of Potentially Misvalued Codes for CY 2010

CMS completed their own review of the AMA RUC recommendation. For some codes, they accepted RUC's recommendation and for others, they did not. The values for the new services are interim values for the next calendar year.

The RUC continued its review of potentially misvalued codes using various screens to include codes with site of service anomalies, high IWP/UT, high volume, fastest growing procedures, and other CMS requests. For CY 2010, RUC submitted recommendations for 113 codes. Of those, 1 was recommended for a reduction in valuation, 7 were recommended for an increase in valuation, 11 were recommended to maintain the same valuation, 45 were referred to CPT for further code clarification, 33 were recommended for practice expense changes and 16 were recommended for clinical labor revision.

Table 5 shows CY 2010 CMS interim work RVUs for potentially misvalued codes reviewed by the AMA RUC in CY 2010.

Establishing Appropriate Relative Values for Physician Fee Schedule Services

Proposed: CMS seeks comments on the MedPAC recommendation to establish a panel of experts separate from the AMA RUC to review the relative values that have been assigned to services.

ACR comments: We stated that we oppose the creation of such a panel. The ACR pointed that the composition of the panel would not be sufficiently representative of the entire spectrum of medical practice and this could lead to the inaccurate valuation of certain services. Instead of creating yet another panel, the ACR believes that CMS should continue to work with the RUC on ways to enhance its consideration of potentially misvalued services, including potentially overvalued services. The ACR stated that the existing process has the greatest potential to address issues raised by MedPAC without leading to unintended consequences. Creation of an additional panel would be associated with increased cost to CMS and seems unnecessary given the resources available from the RUC.

Final rule: CMS stated that they will take comments received into consideration as they continue to explore this issue.

Some commenters suggested that CMS consider enhancing the existing refinement panel process used to address the comments received on interim work RVUs. CMS stated that any revisions to this process would be discussed in future rulemaking.

Five-Year Review

CMS is preparing for the fourth five-year review for physician work. This process is already being discussed at the RUC meetings. CMS offered several observations about what they expect to take place in this process that might be of interest.

1) When submitting codes to the RUC for review, CMS notes that in order to maintain relativity, they may decide to submit the entire family of codes (including the base code) for review. They go on to explain that the base code is the most important code to review because it is the basis for the valuation of other codes within the family and allows for all related codes to be reviewed at the same time. CMS believes that reviewing the entire family of codes can assist in ensuring relativity between services and consistent valuation of services.

2) CMS notes that codes that have been reviewed/revised under the potentially misvalued codes initiative may also be considered for review under the Five-Year Review of work RVUs.

3) For purposes of the fourth Five-Year Review of work RVUs and in order to gain a better understanding of the distribution of data from surveys and other data sources submitted in support of work RVU refinements, CMS will require that the minimum/maximum values, the 5th, 25th, 50th (median), 75th, and 95th percentiles be reported. In addition, they will require reporting of the geometric mean. This is similar to information currently reported for the specialty surveys, with some additional percentiles and the geometric mean being included. If the AMA RUC recommendation does not include the information discussed above CMS may reject the recommendation.

4) To the extent the PQRI databases may include information similar to that previously described in the physician surveys, these databases might serve as an additional source for establishing or validating work RVUs.

5) CMS will publish a proposed notice for the Five-Year Review separate from the annual notice of proposed rulemaking that is published for the PFS in the spring of 2011.

6) The changes will be effective January 1, 2012.

CMS advised that the five-year review of malpractice RVUs is taking place in this proposed and final rule process. (see section II.C. of the final rule).

CMS also advised that they consider the incorporation of the new Physician Practice Information Survey (PPIS) data as the first five-year review process for practice expense. Review of practice expense inputs of various existing codes is ongoing. The next Five-Year Review of PE RVUs will be addressed in CY 2014. CMS is soliciting comments on approaches to take for this next Five-Year Review of PE RVUs.

Process for Establishing Work Relative Value Units for the Physician Fee Schedule

Any new CPT codes and relative values released in the MPFS final rule are considered as interim values for one year. If a specialty comments during the legal 60 day comment period on these values and asked for CMS to readdress their assigned value, CMS will do so in an independent panel process.

Review of 2009 Interim Values

CMS convened a multispecialty panel of physicians to assist us in the review of comments on interim values for 2009. CMS invited representatives from the organizations from which we received substantive comments to attend a panel for discussion of the code on which they had commented.

Stereotactic Radiosurgery Codes

| CPT Code | Descriptor | RUC Value | CMS Value | CMS Final |
|----------|------------------------------|-----------|-----------|-----------|
| 61796 | Stereo radiosurgery, simple | 15.50 | 10.79 | 13.83 |
| 61798 | Stereo radiosurgery, complex | 19.75 | 10.79 | 19.75 |
| 63620 | Stereo radiosurgery, spinal | 15.50 | 10.79 | 15.50 |

Proposed: For CPT codes 61796, [Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion], 61798, [Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); complex], and 63620, [radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion] the AMA RUC recommended 15.50 work RVUs for CPT code 61796, 19.75 work RVUs for CPT code 61798, and 15.50 work RVUs for CPT code 63620.

CMS disagreed with the AMA RUC recommendations and assigned 10.79 work RVUs to all three of these codes in the CY 2009 PFS final rule with comment (73 FR 69892). CMS believed the specialty societies and the AMA RUC, in general, used open surgical codes as comparators during the AMA RUC process instead of a more equivalent stereotactic radiation treatment code.

Specialty Comments: The commenters disagreed with the interim work RVUs assigned by CMS and urged CMS to accept the AMA RUC-recommended values for these codes. The commenters believed CMS erred in basing the interim values on the work RVUs of two radiation oncology services instead of surgical codes. The commenters expressed that stereotactic radiosurgery is much more intense than radiation therapy. Commenters were also confused as to why CMS valued CPT codes 61796, 61798, and 63620 identically since CPT code 61796 describes treatment of a “simple” cranial lesion and CPT code 61798 describes treatment of a “complex” cranial lesion. The commenters believed the work required to treat complex lesions is much greater than the work required to treat simple lesions.

Final rule: As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, CMS has assigned 13.83 work RVUs to CPT code 61796, 19.75 work RVUs to CPT code 61798, and 15.50 work RVUs to CPT code 63620.

Review of 2010 Interim Values

There were many new radiology and radiation oncology CPT codes developed for 2010. Among the brand new codes were cardiac CT and coronary CTA and computed tomography colonography codes. Some of the new codes such as those for myocardial perfusion were developed as a result of the RUC review of codes that should be bundled and therefore were more of a code restructure process. We can expect to see more of this code restructuring in the future. The RUC submits its approved values to CMS for its acceptance in the Medicare Physician Fee Schedule. However, sometimes CMS does not accept the recommended RUC values and chooses to revise the values to a different level (usually lower). Below is a discussion of the radiology codes where CMS did not accept the RUC recommended value. If ACR disagrees with these changes then comments need to be made in this legal 60-day comment period. CMS will then convene a panel in

the coming year, as described above and in the final rule, where experts will be allowed to defend a different value.

Computed Tomography Colonography

| Code | Descriptor | RUC Value | CMS Value |
|-------|--------------------------------|-----------|-----------|
| 74261 | CT colonography, w/o contrast | 2.40 | 2.28 |
| 74262 | CT colonography, with contrast | 2.50 | 2.50 |
| 74263 | CT colonography, screening | 2.28 | 2.28 |

CMS disagrees with the AMA RUC-recommended value and believes the diagnostic computed tomography colonography (CTC) code is comparable to the CTC screening code. CMS notes that the image post processing virtually has the same description of work, pre-, intra-, and post service time for which the AMA RUC recommended 2.28 work RVUs. Therefore CMS has assigned 2.28 work RVUs to CPT code 74261. CMS also notes that screening CTC is a non-covered service because it does not have statutory authority such as has been provided for mammography, diabetes and colorectal cancer screening. This means that legislative action will be necessary in order to get the status of CTC screening changed to a covered service.

Myocardial Perfusion Imaging

| Code | Descriptor | RUC Value | CMS Value |
|-------|-------------------------------------|-----------|-----------|
| 78451 | Myocardial perfusion imaging, SPECT | 1.40 | 1.38 |
| 78452 | Myocardial perfusion imaging, SPECT | 1.75 | 1.62 |

CMS disagrees with the AMA RUC-recommended value for code 78451 [Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)] and for code 78452 [Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection.]

For CPT code 78451, CMS states that it was unclear what methodology the AMA RUC used to calculate the recommended RVU. CMS believes the work RVU for the 25th percentile is more appropriate and has assigned 1.38 work RVUs to CPT code 78451.

For CPT code 78452, CMS disagrees with the reference code used, CPT code 70496, [Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image post processing] which is assigned 1.75. CMS believes CPT code 78452 is comparable to CPT code 73219, [Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)], which is assigned 1.62 work RVUs and the same pre-, intra-, and post- service time. Therefore,

CMS has assigned 1.62 work RVUs to CPT code 78452.

Methodology for the Revision of Resource-Based Malpractice RVUs

Proposed: CMS proposed to alter policies relating to the valuation of technical components, using premium data for medical physicists instead of historical allowed charges. Use of this data provided only a small amount of value (.01) and the CMS rounding process set all the radiology and radiation oncology technical component malpractice values to zero. Also CMS indicated that it could not find sources of premium data for IDTFs, radiology and radiation oncology offices in order to calculate or justify any other malpractice value.

ACR comments: ACR commented that the malpractice values for the professional as well as the TC go to zero for certain procedures which is not logical as there is always some malpractice associated with both the professional and technical components of imaging services. The ACR does not believe that CMS has adequately accounted for this in its proposed methodology and therefore recommended a retention of the current methodology for determining malpractice values for the technical component because imaging centers bear the risk of lawsuits for adverse actions directly related to the liability of their employees in performing the TC.

The ACR strongly encouraged CMS to use the malpractice information submitted by the RBMA for calculations of malpractice values. The information collected shows that the mean for the total annual liability premiums is \$31,526. The ACR also recommended that CMS consult with the RBMA regarding liability policies and premiums paid by freestanding imaging centers.

Final rule: CMS acknowledged that RBMA submitted the names of several insurance companies who provide malpractice insurance for IDTFs, radiology and radiation oncology offices. CMS contacted these insurance companies in an attempt to collect premium data for the suppliers of TC services. They were able to verify the premium information and are using this verified premium data in the calculation of the malpractice RVUs for TC services.

In some circumstances, the information submitted by the commenters included insurance coverage beyond the scope of the malpractice RVUs (for example, property liability, errors and omissions liability) and/or coverage limits beyond the \$1 million/\$3 million coverage malpractice premium collection parameters used for professional services. Therefore, some of the information submitted in the RBMA calculations could not be used.

CMS also agrees that it would be inappropriate for services to receive zero payment for malpractice due to rounding. The calculated medical physics malpractice value of .01 will also be recognized for CY 2010.

“Stand in the Shoes”

Proposed: CMS proposed to clarify part of its “stand in the shoes” (SITS) provision in the Stark self-referral regulations. If adopted, all physicians in a physician organization, whether or not they stand in that organization’s shoes and thus are deemed to have a

Stark-covered financial relationship with it, would not have to sign a writing confirming the terms of a compensation arrangement between their physician organization and an entity furnishing designated health services (DHS).

ACR comments: ACR advised CMS that it firmly supports CMS' Congressional mandate to regulate certain referral arrangements that may attempt to circumvent Stark prohibitions. Such arrangements may risk causing patient abuse and jeopardize program integrity. However, ACR agreed that physicians who stand in their physician organization's shoes should be able to rely on their authorized signatory to execute all appropriate contracts binding the organization (including its members, employees and independent contractor physicians). Therefore, ACR determined that the proposed language appropriately balanced safeguarding against the potential for abuse with minimizing administrative burdens on physicians.

Final rule: CMS adopted its proposal intact. Therefore, the regulation text will not define the term "parties." CMS will not deem any particular physician to have signed an agreement that she or he did not actually sign. This could benefit ACR members who belong to physician organizations with multiple agreements.

Solicitation of Comments - Services Provided "Under Arrangements"

Notably, CMS has opened the door to one of the more controversial elements of Stark. It solicits public comment on various aspects of the Stark definition of "entity" as that relates to services provided "under arrangements." In Phase I of the Stark regulations, CMS defined "entity" as a person or entity that billed Medicare for designated health services – but not the person or entity that actually performed the DHS (where that person or entity did not bill for it). However, CMS became concerned that the definition would permit suspect arrangements that might cause overutilization and compromise medical judgment. Thus, in its FY 2009 IPPS final rule, CMS revised "entity" to also include the person or entity that has "performed services that are billed as DHS." CMS did not define "entity" more specifically. But it noted that a physician or physician organization would perform a "service" if they do the "medical work" for the service and could bill for it, but instead contracts with a hospital that bills for the service. For example, if an imaging center performs an imaging study for which a clinician's group practice bills, CMS would treat the center and group as an "entity" for Stark purposes. This change took effect October 1, 2009.

The Agency in the CY2010 final rule has not proposed to define "entity" further. Yet it wants to know how the industry has dealt with that term and whether it needs to issue further guidance. For instance, should CMS define or clarify "performed services billed as DHS" and if so, how? Should CMS assess performance of a DHS-billable service based on how much of the following parties do: 1) lease space, equipment and supplies that are not separately billable but key to the service; 2) management services; 3) billing services and 4) nonphysician services that are not separately billable but used in the service? How much should the amount and nature of services that physicians and non-physicians (e.g., technicians) affect deciding whether a person or organization has performed services billed as DHS? Staff would appreciate members' perspectives on whether and how the Stark change has influenced their contracted services.

Miscellaneous PE issues

The AMA RUC reviewed and recommended revisions to the clinical labor staff type, supplies, and equipment for the high dose radiation therapy (HDRT) codes (CPT codes 77785, Remote afterloading high dose rate radionuclide brachytherapy; 1 channel, 77786, Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels, 77787, Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels).

Proposed: The AMA RUC recommended further discussion between the specialty and CMS regarding a resolution regarding the useful life of Iridium-192 source. The AMA RUC and other commenters stated that the useful life of the Iridium-192 source is 70 to 90 days. However, many commenters stated that physician offices enter into 1 year contracts for its replacement.

ACR comments: ACR sat silent

Final rule: Based on the comments received and further analysis, CMS is changing the useful life of the Iridium-192 source from 5 years to 1 year and it will be considered as equipment. CMS also is revising the direct PE inputs for clinical labor staff type, supplies, and equipment.

Consultation Codes

Proposed: CMS proposed to delete the consultation codes and allow for these consultations to be billed under new and established office visits. This change will be made in a budget neutral manner where the work, practice expense and malpractice relative values of the consultation codes will be added to the designated E/M codes.

ACR comments: ACR sat silent

Final rule: Effective January 1, CMS will move forward with this proposal. CMS points out that discontinuing the use of the consultation codes does not imply discontinuing payment for consultation services, but only discontinuing the payment differential between consultations and visits. These services will continue to be reported, coded, and paid under the PFS using the new and established office visit E/M codes.

Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)- Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Proposed: CMS has proposed to put out a letter in November 2009 requesting outside organizations to apply to qualify as accrediting organization to help CMS meet the MIPPA requirement to only pay for CT, MR and nuclear medicine for sites that are accredited as of January 1, 2012. CMS needs to meet the deadline of designating accrediting suppliers by January 1, 2010. CMS also solicited comments on many process and qualifying issues.

ACR comments: ACR submitted an extensive set of comments describing ACR's accreditation programs and asking process and technical questions that we felt need to be clarified in regulations moving forward.

Final rule: CMS replied that they still expect to meet the January 1, 2010 statutory deadline in order to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services. They have announced that they are now accepting

applications and ACR has publicly announced that they will apply. CMS indicated that a panel would evaluate all proposals from accrediting organizations seeking designation and is using existing CMS survey and certification processes. CMS went on to answer all the questions of the commenters about the process of accreditation and qualifications of applicants. More details can be provided upon request.

Radiology Assistants

Proposed: Within the MIPPA accreditation section, CMS asked what the role of the radiology assistant is with respect to performing advanced medical imaging and asked for information on any specific credentialing.

ACR comments: ACR/ASRT/ARRS submitted a separate comment letter advising CMS that radiology assistants do not play a major role in the performance of CT and MR studies, this is done by a radiology technologist. The letter then outlined what radiology assistants do, the specific credentialing they undergo and a request to have them recognized under different supervision levels than what are currently specified in CMS regulations.

Final: CMS acknowledged the receipt of comments and said they appreciate the information provided by the commenters as it will assist in understanding the role these individuals play in the provision of imaging services. Thus no action was taken for 2010 and there were no commitments to address this issue in future regulations.

Physician Fee Schedule Update – conversion factor

Proposed: CMS proposes to remove physician-administered drugs from the definition of physicians' services for purposes of sustainable growth rate (SGR) calculations.

ACR comments: The ACR applauded the Administration for taking this step, which the physician community has been urging for quite some time. The ACR especially supported CMS' decision to remove drugs from the calculation of allowed and actual expenditures for all prior years. The ACR believes that these actions will help address at least one of the flaws inherent in the existing SGR methodology, even though this adjustment will not provide immediate relief to physicians.

Final rule: CMS is finalizing their proposal to remove drugs from the calculation of the SGR beginning with 2010. CMS is removing physician-administered drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act for CY 2010 and retrospectively to the 1996/1997 base year in this final rule.

In order to determine the 2010 PFS CF update, the CFs for 2007, 2008, and 2009 must be calculated as if the various legislative changes to the CFs for those years had not occurred. Consistent with the formula specified by the statute, the CY 2010 CF update is -21.2 percent (0.78760).

Regulatory Impact

Below are the cumulative impacts of the policy changes in this rule excluding the potential change in the conversion factor of -21.2% if Congress does not act.

| | Specialty | Allowed Charges (mil \$) | Impact of Work RVU Changes | Impact of PE RVU Changes** | | Impact of MP RVU Changes | Combined Impact | |
|----|--------------------------|--------------------------|----------------------------|----------------------------|------|--------------------------|-----------------|------|
| | | | | Full | Tran | | Full | Tran |
| 21 | INTERVENTIONAL RADIOLOGY | 225 | -1% | -9% | -2% | 0% | -10% | -3% |
| 25 | NUCLEAR MEDICINE | 74 | -5% | -15% | -10% | -2% | -23% | -18% |
| 36 | RADIATION ONCOLOGY | 1,809 | 0% | -3% | 0% | -2% | -5% | -1% |
| 37 | RADIOLOGY | 5,056 | 0% | -14% | -3% | -2% | -16% | -5% |

* Does not include the impact of the current statute CY 2010 negative update except as applied in the OPPS imaging cap comparison (see next footnote). Rows may not sum to total due to rounding.

** Note: The statute caps the PFS imaging payment amount at the comparable payment amount in the hospital outpatient prospective payment system (OPPS) cap. In the absence of the negative current statute CY 2010 PFS update, the proposed fully implemented PE change to the equipment utilization rate for expensive diagnostic equipment from 50 percent to 90 percent would increase expenditures by less than 1 percent due to a loss of savings from the OPPS cap.

Below are code-specific impacts as a result of policy changes in this rule. The impact is based on the 2009 conversion factor and using 2010 HOPPS rate.

| Code | MOD | DESCRIPTION | SI | 2009 Payment Rate | 2010 payment rate | Fully implemented payment rate | % change 2009 vs. 2010 | % change 2009 vs. fully implemented |
|-------|-----|---------------------------|----|-------------------|-------------------|--------------------------------|------------------------|-------------------------------------|
| 70450 | | Ct head/brain w/o dye | A | \$218.56 | \$192.59 | \$130.92 | -12% | -40% |
| 70450 | TC | Ct head/brain w/o dye | A | \$174.92 | \$149.67 | \$90.17 | -14% | -48% |
| 70450 | 26 | Ct head/brain w/o dye | A | \$43.64 | \$42.92 | \$40.75 | -2% | -7% |
| 70460 | | Ct head/brain w/dye | A | \$282.40 | \$250.66 | \$173.84 | -11% | -38% |
| 70460 | TC | Ct head/brain w/dye | A | \$224.69 | \$193.67 | \$119.02 | -14% | -47% |
| 70460 | 26 | Ct head/brain w/dye | A | \$57.71 | \$56.98 | \$54.82 | -1% | -5% |
| 70470 | | Ct head/brain w/o & w/dye | A | \$341.91 | \$302.59 | \$207.38 | -11% | -39% |
| 70470 | TC | Ct head/brain w/o & w/dye | A | \$276.99 | \$238.40 | \$145.71 | -14% | -47% |
| 70470 | 26 | Ct head/brain w/o & w/dye | A | \$64.92 | \$64.20 | \$61.67 | -1% | -5% |
| 71010 | | Chest x-ray | A | \$23.80 | \$23.08 | \$21.28 | -3% | -11% |
| 71010 | TC | Chest x-ray | A | \$14.79 | \$14.07 | \$12.26 | -5% | -17% |
| 71010 | 26 | Chest x-ray | A | \$9.02 | \$9.02 | \$9.02 | 0% | 0% |
| 71275 | | Ct angiography, chest | A | \$450.47 | \$437.85 | \$433.52 | -3% | -4% |
| 71275 | TC | Ct angiography, chest | A | \$352.01 | \$340.47 | \$340.47 | -3% | -3% |
| 71275 | 26 | Ct angiography, chest | A | \$98.46 | \$97.38 | \$93.05 | -1% | -5% |
| 71551 | | Mri chest w/dye | A | \$515.03 | \$510.91 | \$407.91 | -1% | -21% |
| 71551 | TC | Mri chest w/dye | A | \$427.39 | \$423.99 | \$323.87 | -1% | -24% |
| 71551 | 26 | Mri chest w/dye | A | \$87.64 | \$86.92 | \$84.03 | -1% | -4% |
| 72128 | | Ct chest spine w/o dye | A | \$253.55 | \$252.82 | \$174.20 | 0% | -31% |
| 72128 | TC | Ct chest spine w/o dye | A | \$194.40 | \$194.04 | \$117.94 | 0% | -39% |

| | | | | | | | | |
|-------|----|-------------------------|---|----------|----------|----------|------|------|
| 72128 | 26 | Ct chest spine w/o dye | A | \$59.15 | \$58.79 | \$56.26 | -1% | -5% |
| 72146 | | Mri chest spine w/o dye | A | \$429.55 | \$430.68 | \$298.63 | 0% | -30% |
| 72146 | TC | Mri chest spine w/o dye | A | \$348.04 | \$349.53 | \$220.72 | 0% | -37% |
| 72146 | 26 | Mri chest spine w/o dye | A | \$81.51 | \$81.15 | \$77.90 | 0% | -4% |
| 74160 | | Ct abdomen w/dye | A | \$363.55 | \$323.51 | \$224.33 | -11% | -38% |
| 74160 | TC | Ct abdomen w/dye | A | \$298.27 | \$259.31 | \$162.66 | -13% | -45% |
| 74160 | 26 | Ct abdomen w/dye | A | \$65.28 | \$64.20 | \$61.67 | -2% | -6% |
| 76705 | | Echo exam of abdomen | A | \$103.15 | \$100.62 | \$96.30 | -2% | -7% |
| 76705 | TC | Echo exam of abdomen | A | \$72.85 | \$71.05 | \$67.80 | -2% | -7% |
| 76705 | 26 | Echo exam of abdomen | A | \$30.30 | \$29.57 | \$28.49 | -2% | -6% |
| 77080 | | Dxa bone density, axial | A | \$71.77 | \$61.67 | \$44.72 | -14% | -38% |
| 77080 | TC | Dxa bone density, axial | A | \$61.67 | \$51.57 | \$34.62 | -16% | -44% |
| 77080 | 26 | Dxa bone density, axial | A | \$10.10 | \$10.10 | \$10.10 | 0% | 0% |
| 77055 | | Mammogram, one breast | A | \$84.76 | \$82.59 | \$77.90 | -3% | -8% |
| 77055 | TC | Mammogram, one breast | A | \$49.05 | \$47.25 | \$44.00 | -4% | -10% |
| 77055 | 26 | Mammogram, one breast | A | \$35.71 | \$35.34 | \$33.90 | -1% | -5% |
| 77056 | | Mammogram, both breasts | A | \$107.48 | \$105.31 | \$100.26 | -2% | -7% |
| 77056 | TC | Mammogram, both breasts | A | \$63.12 | \$61.31 | \$58.07 | -3% | -8% |
| 77056 | 26 | Mammogram, both breasts | A | \$44.36 | \$44.00 | \$42.20 | -1% | -5% |
| 77057 | | Mammogram, screening | A | \$81.51 | \$78.26 | \$72.13 | -4% | -12% |
| 77057 | TC | Mammogram, screening | A | \$45.80 | \$42.92 | \$38.23 | -6% | -17% |
| 77057 | 26 | Mammogram, screening | A | \$35.71 | \$35.34 | \$33.90 | -1% | -5% |

Section 131(b) Physician Payment, Efficiency, and Quality Improvements -- Physician Quality Reporting Initiative (PQRI)

Registry-Based Reporting Mechanism

Proposed: CMS intends to lessen reliance on claims-based reporting of PQRI data.

ACR comments: ACR commented claims-based reporting should not be totally discontinued for several reasons 1) numerous practice locations where radiologist may not control data needed to report to CMS 2) the cost to utilize a registry, 3) the inability to report 3 measures thus ineligibility for registry reporting.

Final rule: CMS received many comments that claims-based reporting should not be limited or eliminated in 2011. CMS recognized that for many eligible professionals, claims-based reporting is the only option available for participating in PQRI. CMS anticipates continuing to offer claims-based reporting options for PQRI beyond 2010.

Reporting Periods

Final rule: CMS announced that a 6-month reporting period beginning July 1, 2010 will be an option for claims-based reporting, in addition to 12 month reporting (January –

December). In 2008 and 2009, only a 12 month reporting period was available for claims-based reporting. Registry based reporting offered a 6 month reporting option in 2008 and 2009. To be consistent across reporting mechanisms and in response to many comments regarding barriers to beginning participation on January 1 of the new reporting period, CMS decided to add the 6 month option for claims reporting. Barriers to participation on January 1 include slow turnaround time of previous year feedback reports on an eligible professional's reporting success and lack of time to implement new measures when specifications are not posted until December prior.

The incentive payment of 2% for successful reporting is based on total allowable charges for the reporting period, i.e. January – December or July – December.

Minimum Patient Sample Requirement – Individual Measures

Proposed: CMS proposed an additional criterion for successful reporting of individual measures in 2010 – a minimum patient sample size for at least one measure. Based on further analysis of 2008 PQRI data and many comments, CMS determined that the requirement for one measure with a minimum sample size of 15 would adversely impact a significant number of professionals' ability to successfully report. CMS may revisit a minimum patient sample size in future years.

Criteria for Satisfactory Reporting Measures Groups

Proposed: CMS proposed changing one of the requirements for eligible professionals reporting on measures groups (Interventional Radiologists may be able to report the Perioperative Care Measures Group). In 2008 and 2009, one option for reporting a measure group was to report that measure group on 30 consecutive patients during the reporting period. CMS proposed changing that option to report on any 30 unique patients seen during the reporting period.

Final rule: CMS will finalize the proposed change so that a measure group can be reported on any 30 unique patients during the reporting period.

2010 Measure Selection

Proposed: CMS proposed retiring Measure #11 and replacing it with a revised measure, Stenosis Measurement in Carotid Imaging Reporting.

ACR comments: ACR commented it was pleased that CMS has proposed inclusion of as a replacement for Carotid Imaging Reporting (Measure #11). The revised measure allows greater participation by radiologists because of the expanded patient population; the benefits gained through compliance with the measure will also be extended to a broader population.

Final rule: CMS finalized inclusion of the revised measure, Stenosis Measurement in Carotid Imaging Reporting to replace the retired Measure #11, Carotid Imaging Reporting.

Proposed: CMS proposed removing two oncology measures, 143: Oncology: Medical and Radiation – Pain Intensity Quantified and measure 144: Oncology: Medical and Radiation - Plan of Care for Pain from the 2010 program for being “analytically challenging”.

ACR comments: ACR commented that removing Measure 143 and 144 was a step backward in CMS' goal to increase participation in the PQRI program, and suggested retaining the measures as registry-only submission measures.

Final rule: CMS will retain Measure 143 and 144 in 2010 PQRI as registry only measures.

Public Reporting of PQRI Data

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

ACR comments: The ACR encouraged CMS to be specific and clear in posting the information that successful reporting is just that – successful reporting – and does not necessarily indicate higher quality care was or will be provided by those individuals who earned PQRI incentive payments.

Final rule: CMS finalized its intent to post “enhanced” information related to PQRI reporting as stated in the proposed rule. CMS believes it will or has addressed many suggestions and concerns submitted by commenters including allowing eligible professionals to have an opportunity to review their reporting results prior to public posting and accompanying publicly reported information with a disclaimer that address the potential uses and limitations of the information – including the fact that successful reporting does not necessarily indicate higher quality care was or will be provided by those individuals who earned PQRI incentive payments.