



August 30, 2011

Donald Berwick, MD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1524-P  
Mail Stop C4-26-05  
7500 Security Blvd  
Baltimore, MD 21244-1850

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

Dear Administrator Berwick:

The American College of Radiology (ACR), representing more than 34,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, is pleased to submit comments on the proposed changes to the 2012 Medicare Physician Fee Schedule (MPFS) and other issues affecting Part B services. The ACR would like to comment on several major issues in this rule including the proposed changes to multiple procedure payment reductions (MPPR), potentially misvalued services under the physician fee schedule including: direct practice expense inputs, referral of high expenditure Current Procedural Terminology (CPT®) codes for the Relative Value Scale Update Committee (RUC) review, consolidation of reviews of potentially misvalued services, codes without direct practice expense inputs in the non-facility setting, ultrasound equipment, and payment for bone density tests (DEXA). Additionally, the ACR is commenting on the Physician Quality Reporting Inactive.

**Potentially Misvalued Codes under the Physician Fee Schedule**

***Multiple Procedure Payment Reduction***

The ACR strongly urges the Centers for Medicare & Medicaid Services (CMS) not to extend the 50 percent multiple procedure payment reduction to the professional component (PC) of advanced imaging services. The ACR believes that extending this policy to the PC is unfounded as there are no more than 5 percent efficiencies in the PC when two studies are furnished to the same patient by the same physician. It appears that CMS' decision to apply an MPPR to the PC of diagnostic imaging services is rooted in

**Headquarters**  
1891 Preston White Dr  
Reston, VA 20191  
(703) 648-8900

**Government Relations**  
505 9<sup>th</sup> Street NW, Suite 910  
Washington, DC 20004  
(202) 223-1670

**Clinical Research**  
1818 Market St, Suite 1600  
Philadelphia, PA 19103  
(215) 574-3150



the incorrect assumption that there are considerable efficiencies when radiologists interpret successive imaging studies during a single patient visit. However, radiologists are morally and professionally obligated to expend an equal amount of time, effort, and skill on interpreting images, regardless of whether or not a previous examination has been performed on the same day. Each imaging study produces its own unique set of images that must be interpreted in its entirety, separately dictated and written in separate reports to the referring physicians. Clinical settings where patients will require multiple examinations on the same day include severe trauma, cancer diagnosis and follow-up and stroke, making the overall medical complexity of patients requiring multiple examinations typically greater than patients requiring single examinations. A comprehensive review of a clinical example using the same modality in a similar anatomic area is provided in Attachment A. Efficiencies across different modalities and different anatomic regions would be far less defensible.

It has come to our attention that during a recent Midwest tour of healthcare facilities, you and members of Congress had the opportunity to meet with radiologists in St. Paul, Minnesota and in Eau Claire, Wisconsin. Dr. Berwick, we are sincerely grateful that you took the time to observe the activities of radiologists in the sites where they provide care. During a tour of an imaging facility in St. Paul, the radiologists on site showed you what it was like to interpret multiple examinations on the same patient. You indicated to them that there “aren’t many efficiencies” when interpreting multiple studies. During your visit to rural Wisconsin, radiologists shared with you how they try to ensure that patients requiring multiple examinations have as many of their necessary examinations as possible on the same day in order to lessen the hardships of having to travel large distances. The radiologists expressed their concern that the proposed MPPR would limit a patient’s ability to receive efficient care. These radiologists told us that you also commented, “The efficiencies were more appropriate on the technical side rather than the professional side.”

As justification for its proposed 50 percent PC MPPR, CMS cites the multiple surgery reduction as a long-standing policy of the agency to handle multiple procedures reported together. CMS also states that this proposal is consistent with recommendations from a 2009 Government Accountability Office (GAO) report to Congress, recent MedPAC recommendations and recent actions by the RUC regarding the bundling of computed tomography of the abdomen and pelvis. However, we do not believe any of these arguments support the CMS proposal for a 50 percent MPPR.

#### MPPR for Multiple Surgical Procedures

As justification for the 50 percent reduction in payment, the proposed rule cites the 50 percent surgical discount as precedent for advanced imaging services which have XXX global periods. The surgical MPPR was finalized in the November 25, 1991 Final Rule and follows what was at the time the most common carrier pricing scenario, which reduced payment for a second procedure by 50 percent. The surgical MPPR is generally applicable to procedures with a 90-day global period because there is efficiency in work



and practice expense in pre-service office visits, post-operative hospital care, and post-operative office visits, since these are activities not typically duplicated when two surgical procedures are performed. For example, a common 90-day global surgical service CPT code 47600 (cholecystectomy) has total RVUs of 17.48. According to data from the RVS Data Manager, 8.65 RVUs of the total RVUs (55.2 percent) occurs during the pre and post-service periods. Appropriately, no discount is specifically applied to the intra-service work of the second procedure.

<b>47600</b>	<b>Cholecystectomy</b>
Total RVU	17.48
Pre- and Post-Service RVUs	9.65
Intra-service RVUs	7.83
<b>Percentage Pre- and Post-service RVUs</b>	<b>55.21%</b>

In contrast, using the same analysis of data from the RVS Data Manager for a common computed tomography (CT) code pair, 72160 and 72192, only 15 percent of the total work occurs in the pre- and post-service periods. Even if none of the pre and post-service work were duplicated in the second service, the CMS proposal for a 50 percent MPPR would also discount the intra-service work of the second examination greater than 48 percent.

The 2009 GAO Report<sup>1</sup>

The ACR believes that the 2009 GAO report, used as the basis for MedPAC’s recommendation and referenced by CMS in the proposed rule, mischaracterizes potential savings based on efficiencies in pre-service and post-service work when two or more services are performed together. The GAO chose CT of the abdomen and pelvis as the sole example of a combination of services which may yield efficiencies when performed together. In their analysis of this code pair, the GAO equates less intense pre-service and post-service work with more intense intra-service work, which dramatically overstates the potential savings. This flaw in the understanding of the valuation of physician work in the MPFS makes us question the validity of the entire report. For a number of reasons, this code pair, performed together 90 percent of the time, had some definable overlap in both pre-service and post-service work, as well as overlap in intra-service work due to overlap in imaging of the contiguous anatomic areas. In our opinion, this code pair, which was recently bundled by the CPT Editorial Panel (EP) and valued by the RUC, represents the highest level of efficiency that could possibly be attained when two diagnostic imaging examinations are performed together. Not only is it commonplace for these services to be performed together, there is inherent anatomic overlap between the

<sup>1</sup> GAO, Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together, GAO-09-647, July 2009, at 15, <http://www.gao.gov/new.items/d09647.pdf>.



abdomen and pelvis, and the RUC carefully considered this in its deliberations. There is no such anatomic overlap between most other contiguous examinations; and there is zero overlap when the imaged body parts are non-contiguous, or when different modalities are used. This was recognized in the GAO report, which stated that the results of the CT abdomen and pelvis example should not be extrapolated to other services.

The ACR also believes that CMS misinterpreted the recommendations of the July 2009 GAO report. The proposed rule states that the GAO recommended:

- (1) expanding the existing imaging MPPR policy for certain services to the PC to reflect efficiencies in physician work for certain imaging services; and
- (2) expanding the MPPR to reflect PE efficiencies that occur when certain nonsurgical, non-imaging services are furnished together.

The GAO's actual recommendations were for CMS to "take further steps to ensure that fees for services paid under Medicare's physician fee schedule reflect efficiencies that occur when services are performed by the same physician to the same beneficiary on the same day." According to the GAO, "These efforts could include systematically reviewing services commonly furnished together and implementing an MPPR to capture efficiencies in both physician work and practice expense, where appropriate, for these services." Similar to MedPAC, the GAO recommended that CMS would need to "systematically" review services commonly performed together and that a blanket MPPR might not be appropriate for all services. The GAO also acknowledged that the results of its analysis "cannot be generalized to all service pairs". Contrary to CMS' summary of the report, the GAO did not recommend that CMS simply apply the existing 50 percent MPPR to other services. Instead, the GAO recommended that CMS undertake a thorough review of services and develop an appropriate adjustment based on the outcome of this review. Such an analysis is currently being conducted by the CPT Editorial Panel and the RUC. Thirteen new bundled CPT codes have been developed and valued by the RUC and more bundled codes are being developed for the 2013 and 2014 CPT cycles. These efforts should more than address the GAO recommendation for "systematically reviewing" services commonly furnished together.

### Replicating the GAO Analysis

The GAO took on an empiric analysis of the RVS Data Manager for a select group of CPT codes, but as has been pointed out by the AMA, their methodology was flawed regarding their understanding of intensity of physician work. Additionally, the GAO did not perform a systematic review of all CPT codes but rather looked at only a few examples in order to reach their conclusions. A recent article published in the *Journal of the American College of Radiology* (Attachment B) addresses the flaws in the GAO methodology and provides a comprehensive and systematic review of existing data for imaging services as was recommended by the GAO. This study demonstrates that efficiencies within the PC of advanced diagnostic imaging services are minimal, and vary



greatly across modalities. An expert panel of radiologists reviewed and analyzed data from the AMA Resource Based Relative Value Scale (RBRVS) Data Manager for 2011 to identify physician work efficiencies that occur when more than one diagnostic imaging study is interpreted by the same provider for the same patient during the same session. Data were analyzed to quantify relative contributions of pre-service, intra-service, and post-service physician work to the total work of rendering diagnostic imaging services, and identify potential duplications in pre-service and post-service work. The results of this analysis revealed that:

- the average relative contributions of pre-service and post-service work to total work varied by modality (ranging from 20 percent for CT to 33 percent for ultrasound);
- the maximum percentage of duplicated pre-service and post-service work activities ranged from 19 percent (for nuclear medicine) to 24 percent (for ultrasound); and
- maximum mean potentially duplicated payment for work RVUs ranged from 0.0212 (for radiography) to 0.0953 (for MRI), which correspond to a maximum reduction in Work RVUs of only 2.96 percent (for CT) to 5.45 percent (for ultrasound).

Thus, the authors concluded that while “potential efficiencies in physician work occur when multiple services are provided to the same patient during the same session, [such efficiencies] are highly variable and considerably less than previously estimated.” These findings are in sharp contrast to the GAO report, which indicated that for the code pairs analyzed there was a much higher potential for duplication in payment.

#### MedPAC Recommendations

CMS states that the March 2010 MedPAC report made recommendations “regarding the expansion of MPPR policies under the physician fee schedule to account for efficiencies.” However, the MedPAC did not make such a recommendation in their report. Rather, the MedPAC letter to CMS on the 2011 proposed rule “encouraged CMS to explore an expansion to the PC of imaging services.” The June 2011 MedPAC Report to Congress recommended, “Congress should direct the Secretary to apply a multiple procedure payment reduction to the professional component of diagnostic imaging services provided by the same practitioner in the same session.” That report did not, however, mention applying a 50 percent reduction; instead, it stated that CMS should calculate the payment reduction for the second and subsequent services performed in the same session by analyzing the efficiencies in physician work associated with providing those services. Therefore, MedPAC recognized that any efficiency from providing multiple imaging services in the same session would not be achieved consistently across services, specifically warning that “efficiencies may vary by type of imaging,” and that CMS would need to analyze those efficiencies in order to calculate an appropriate



payment reduction.<sup>2</sup> While MedPAC cited the GAO report as justification for its recommendation, we do not believe MedPAC independently replicated the GAO analysis.

#### Recent RUC Recommendations

CMS also uses the recent valuation by the RUC of the newly combined CT abdomen and pelvis codes as further justification of the MPPR to the PC for advanced imaging services. As we mentioned earlier when we discussed the 2009 GAO report, extrapolating a proposed reduction solely from this single combination of codes that were reported together 90 percent of the time is inappropriate. First, any efficiencies in pre- and post-service work that are found in performing two imaging services using the same modality on contiguous body parts would not necessarily be found when performing services using different modalities or on noncontiguous body parts. CT of the abdomen and pelvis uses the same piece of equipment, and minimal physician directed repositioning or change in protocol would be expected. This is in contrast to other affected imaging services where considerably more physician work would be associated with the pre and post-service periods. In other words, CT of the abdomen and pelvis demonstrates the maximal possible expected efficiency in physician work. Second, it is important to restate that CT of the abdomen and pelvis allows for efficiencies in the intra-service work that would not occur in other combinations of services that would be subject to the MPPR expansion to the PC. In fact, when the GAO reviewed the CT of the abdomen and pelvis code pair, they were careful to note, “the results of our analysis cannot be generalized to all service pairs. Therefore, we do not believe that CMS should generalize this assessment of a single code pair to all advanced imaging services.” Even the RUC, which thoroughly evaluated this code pair, strongly opposed the use of this code pair as justification for a generic 50 percent PC MPPR.

#### Future Expansion of the MPPR Policy

We are also extremely concerned that in addition to the proposed expansion of the MPPR to the PC of advanced imaging codes starting in January 2012, CMS has noted it will be soliciting comments in future rulemaking to expand this policy even further to include the TC of all imaging services, the PC of all imaging services, as well as the TC of all diagnostic services. To our knowledge, CMS has not conducted any analysis on actual efficiencies that would be associated with the current or proposed expanded MPPR policies; it does not make sense for CMS to continue to move ahead in the absence of such analysis.

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<sup>2</sup> Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System*, June 2011, p. 40.



### Impact to Radiologists

In the NPRM, CMS projects reductions in imaging payments of \$100 million a year from its proposal (which would be redistributed to other services) yet offers no explanation for this estimate. Additionally, CMS suggests in Table 64 that the impact to radiologists for RVU and MPPR changes will be 1 percent. However, a preliminary analysis conducted by the Radiology Business Management Association (RBMA) of two dozen radiology practices (Attachment C) shows an average reduction in Medicare payments from the MPPR-PC of approximately 5 percent.

Hardest hit by the MPPR-PC are practices that serve trauma and cancer centers with estimated Medicare payment reductions in the 7 to 8 percent range. This supports our reasoning that the more complex patients are more likely to require multiple examinations, and that the proposed MPPR policy inappropriately targets providers caring for these complex patients. There are little or no efficiencies when multiple PCs are done on the same day, as the work is the same if the patient receives all the care in one session or over a series of days. Therefore, radiologists should not be penalized for providing the most efficient care at the same level of work in one day.

### Consolidated Impacts of Five Years of Payment Reductions for Imaging

Finally, the potential for savings from the policy does not take into account the likelihood that as global payments to physician offices continue to decrease, there will be a shift in care from physician offices to hospital outpatient facilities, where the costs to the Medicare program are significantly higher. This will increase beneficiary costs in the form of higher co-pays. Additionally, there will be adverse effects on local economies if imaging centers continue to close and the access to care for beneficiaries in rural areas will be diminished.

The specialty of radiology and specifically the payments for the advanced imaging modalities have been the focus of payment reductions both legislatively and through the regulatory process for several years now. When CMS was initially proposing and implementing the first iteration of the TC MPPR rule, the Deficit Reduction Act (DRA) was implemented. In addition, the incorporation of flawed data from the Physician Practice Information Survey (PPIS) and the Congressionally-mandated increased equipment usage assumption have created significant reductions in technical component payments for imaging services; and in the last year, the MPPR reduction to the TC was increased to 50 percent, and now applies to all advanced imaging procedures regardless of body part or modality. These additive payment reductions are making it increasingly difficult, even impossible, for many radiologists to keep their offices and freestanding imaging centers open at a time when actual practice costs continue to increase. We have noted that many freestanding imaging centers have been bought by hospitals and as payment reductions are fully implemented, we expect this trend to continue or escalate. Many of the hospitals then bill for services in these newly acquired centers under the more expensive HOPPS schedule. Some policy makers have suggested that the growth in



imaging over the last decade was due to overpricing. However, despite the dramatic payment reductions over recent years, the volume of imaging has remained generally constant. This is because, in most cases, the providers of the imaging services are not the physicians ordering the examinations, and are therefore not affected by imaging payment reductions. In fact, based on recent Medicare volume data, the growth in volume for imaging is congruent with that demonstrable for the rest of medicine. Ironically, when fully implemented, the draconian payment reductions for advanced imaging in the PFS will result in a significant shift in site of service from independent facilities to hospitals where Medicare costs are higher and advanced imaging accreditation is not mandated. Additionally, there will be access issues for some beneficiaries in rural settings, since given the reimbursement cuts, supervision requirements, many independent centers in rural locations will not be able to remain open, and small hospitals will not be able to provide certain advanced imaging services such as positron emission tomography and MRI.

#### Administrative Burden to Radiology Practices

The proposed MPPR-PC will place significant administrative burdens on radiology practices. CMS must understand that the radiology systems in place today are not designed to distinguish between imaging procedures performed during the “same” or “different” sessions with any degree of reliability. If the MPPR-PC is implemented, the challenge to back office operations will be to bill correctly when studies are part of the same session or, more importantly, to determine when a study is separate and distinct from previously performed studies in order to add the -59 modifier. The RBMA has reported to the ACR and notes in their comments that they have spent considerable time speaking to, and working with, its members on this issue. The RBMA has concluded that given today’s systems and the data elements currently available and in use throughout the country, there is no practical method to reliably and efficiently make this distinction. This challenge is made even more difficult when the issue of “same” versus “different” interpreting physician(s) is taken into account. This process will be challenging to auditors as well who will likely suggest that the burden is on the practice to *prove* claims submitted with a -59 modifier actually occurred in a separate session. How this can be efficiently documented is unclear to us, and should be considered before any such policy is adopted. Further, CMS’ own claims processing systems could encounter increased costs as practices struggle to integrate the MPPR requirements, re-submit claims, and file appeals with Medicare intermediaries.

**In summary, the ACR urges CMS not to implement its proposed expansion of the MPPR policy to the PC of advanced imaging services because such across the board cuts are inappropriate and lack justification. Rather, the search for efficiencies should continue to be part of the RUC process, which evaluates services that are performed together on a code-by-code basis.** The ACR has been working diligently and cooperatively in this process, which is part of CMS’ “potentially misvalued services” initiative. The analysis that was published in the *JACR*, which to our knowledge



represents the only systematic review of the RVS Data Manager data, suggests a much lower percentage duplication of professional work, in the range of 3-5 percent. **We urge CMS to give careful consideration to this range, which we believe reflects the maximal amount of work that is not performed when multiple advanced diagnostic imaging services are performed during the same session.** However, prior to instituting a PC MPPR in this range, we also urge CMS to consider the additional administrative burdens and costs that will be faced by practices and Medicare contractors alike, which would substantially negate or reverse any potential savings from the policy.

### *Mandate for a Validation Process*

The ACR strongly believes that the establishment of a formal process to validate codes must be well thought out and properly conducted. As the agency is well aware, the work relative value units (RVUs) play a critical role in determining Medicare reimbursement for physician services. Therefore, it is essential that such values accurately reflect the work associated with a physician's performance of a particular service. The process of establishing and validating codes has been ongoing since the establishment of the RUC process. More recently, specialty societies have been called upon to validate codes that have been identified in the screens of "potentially misvalued" codes in the seven categories identified by the Secretary. The RBRVS is a "relative" payment system that must be studied in its entirety. It would be inappropriate to isolate specific physician services for measurements in a manner that is inconsistent with the remainder of services. This is not unlike the CMS decision to insist on consistent data sources, practice expense and professional liability insurance determinations. While we are in agreement with the comments that CMS received from stakeholders that stated, "time and motion studies to validate estimates of physician time and intensity would be an extraordinarily expensive and burdensome process," we ask the agency to ensure that in implementing a validation process, that the agency will ensure that they only use the highest quality data to validate codes. Further, we urge the agency to make this process transparent and applied across the entire spectrum of physician services, and we ask that the protocol for collection and analysis of data be released for public comment and review before the data are used to validate RVUs.

### *CY 2012 Identification and Review of Potentially Misvalued Services Specialty Society Workload Issues*

CMS' proposed agenda for review of potentially misvalued services does not appear to recognize that there are obvious limits to how many codes a single specialty can be expected to review at any one time. For example, the ACR is concerned about the volume of radiology codes CMS is proposing for RUC review and the time frame for accomplishing this work. In the proposed rule, 11 of the 70 services from Table 7 (Select List of Procedural Codes Referred for AMA RUC Review) are radiology-related. The ACR has cooperated completely in the processes for addressing services in the other



screening categories, and has numerous code proposals in development to address issues surrounding component coding and potential duplicative payment. In fact, some of the codes on this list appear on other screens, for which we are already in the process of developing action plans. To date, this work totals 120 services for which we have prepared RUC recommendations in the past five years, and approximately 59 services slated for review in 2011, 2012 and 2013. If CMS finalizes its proposal and the RUC agrees to a full RUC review of all the proposed services, CMS must recognize that a reasonable timeline is required for a credible evaluation of these services, especially in light of already pending requests for review of radiology and other physician services.

### *Codes Potentially Requiring Updates to Direct PE Inputs*

In the proposed rule, CMS reports that stakeholders have alerted the agency to the fact that the resulting PE RVUs for the newly created bundled CT abdomen and pelvis codes (74176, 74177 and 74178) create a rank order anomaly compared to the existing stand-alone codes (72192, 72193, 72194, 74150, 74160, 74170). CMS indicates that this rank order anomaly is the result of outdated PE RVUs for the stand-alone codes; in fact, it is the PE methodology used by CMS to handle the direct inputs for the new combined codes that has created the payment anomaly. Additionally, codes 74176, 74177 and 74178 incorrectly use a Radiologic Technologist (L014B) as the clinical labor type as opposed to a CT Technologist (L046A). We ask that CMS make this correction in clinical labor type.

Despite predictions that a PE payment rank anomaly would occur, CMS elected not to transition practice expense payments for 74176, 74177 and 74178. This alone creates a significant rank order anomaly; once the base codes are fully transitioned and the clinical labor type is corrected, there will be essentially no rank order anomalies in PE payments in this family of codes.

Additionally, without explanation, CMS has changed its method of allocating clinical labor time to room time as compared to the base codes resulting in anomalous decreases in room time for 74176, 74177 and 74178. In our comments on the Final Rule for 2011 we stated:

“Further, the equipment time for the equipment items is less in the CMS database for all three codes compared to the RUC-approved time - 5 minutes less for 74176, 6 minutes less for 74177 and 6 minutes less for 74178. Consistent with the methodology used for past codes whereby equipment time includes time for which the equipment is unavailable for other patients, the RUC accepted the time associated with greeting the patient, provide gowning, provide pre-service education and obtain consent as part of the total equipment time. However, in reducing equipment times for the three codes, the final rule provides insufficient rationale for departing from this usual approach. The RUC has recognized



that the room cannot be used for another function; during the time allocated for these functions it should count toward total room time.”

In the current proposed rule, CMS addressed our comments by stating:

“As stated in the CY 2011 PFS final rule with comment period (75 FR 73350), we accepted the AMA RUC- recommended direct PE inputs for these codes, *with refinements to the equipment minutes* (emphasis added) to assure that the time associated with the equipment items reflected the time during the intra-service period when a clinician is using the piece of equipment, plus any additional time the piece of equipment is not available for use for another patient due to its use during the designated procedure. We believe that the direct PE inputs of the new codes reflect the typical resources required to furnish the services in question.”

Again, the ACR believes this explanation does not adequately address the allocation of clinical labor time to room time. We are concerned that CMS has applied the PE standards used for surgical codes, including image guided codes, to diagnostic imaging equipment. It is true that the room time for a piece of equipment used for an intervention is directly related to the physician’s intra-service work time. However, this reasoning simply does not apply to imaging examinations when the CT technologist’s time activities determine the equipment time. The physician work associated with these imaging studies involves interaction with the CT technologist, but most of the intra-service work relates to interpreting the acquired images. In summary, for diagnostic imaging services, clinical labor time and room time are not related to physician intra-service time, and room times should not correlate with physician intra-service time. Since there is only one clinical labor staff assigned for these codes, any time spent by that technologist with a patient prevents the CT room from being used for another patient. It would be inappropriate to assign the tasks of greeting the patient, provide gowning, and provide pre-service education and obtain consent to a lesser staff time, since these examinations involve radiation and carry risk which only a registered technologist can communicate.

With the exception of the error of the CMS using a radiologic technologist instead of the CT technologist as the clinical staff person, the bundled codes have appropriately higher direct PE inputs than the base codes. However, the reasons below show how a perceived PE payment rank order anomaly has occurred for the TC of these services:

1) Practice expense payments for 74176, 74177 and 74178 were not transitioned. The ACR recognized that this could create a rank order anomaly with the base codes and asked CMS to transition the bundled codes as well. CMS did not accept our recommendation; therefore, the relativity between the base and bundled codes is lost because of differences in methodology.



2) The Room Time allocation in the bundled codes is inconsistent with the historically accepted premise that if the technologists are involved with a patient, the room cannot be used for a different patient until after it has been cleaned and therefore 100 percent of the clinical labor time should be attributed to “Room Time.” Whether or not this was CMS’ intent, the result is again a difference in PE methodology that is creating the rank order anomaly, not the direct PE inputs.

The effect of these policies on PE RVUs is shown in the Table below:

**CT Abdomen and Pelvis Data Table**

CPT Code	Descriptor	Total Clinical Labor Time	Physician Intra-service Time	Room Time	2011 TC PERVU	2012 TC PERVU	Fully Transitioned TC PERVU
74150	CT Abd C-	38	12	38	5.54	5.04	4.44
74160	CT Abd C+	54	15	47	7.99	7.38	6.62
74170	CT Abd C- /C+	72	27H	65	10.97	10.18	9.18
74176	CT Abd-Pel C-	46	22	27	3.87	4.03	4.03
74177	CT Abd-Pel C+	65	25	42	7.39	7.69	7.69
74178	CT Abd-Pel C-/C+	90	30	57	9.77	10.88	10.88

74150 - 70	CT Tech	0.46/min
74176 - 78	Rad Tech	0.41/min

As a result, methodological inconsistencies have created the rank order anomaly - not the direct PE inputs, which were carefully reviewed for both the bundled and base codes during the RUC evaluation of the bundled codes. While the RUC might reaffirm its recommendation regarding allocation of clinical labor time to room time, revisiting the direct inputs would not help the result, as a comprehensive review occurred recently and contrary to what was stated in the proposed rule, the direct PE inputs for CPT codes 72192, 72193, 72194, 74150, 74160, and 74170 were recently reviewed by the RUC during the process to create the bundled codes. **Therefore, there is no reason for the RUC to duplicate this review. Instead, we ask that CMS review the PE methodology, which appears to be the basis for these anomalies and make appropriate adjustments to the bundled CT of the abdomen and pelvis code. We also request that CMS offer an explanation in the final rule of why the rationale for decreasing room time for the bundled codes versus the existing codes exists.**



***Codes without Direct Practice Expense Inputs in the Non-Facility Setting***

CMS reports that they have received a request from stakeholders to create non-facility RVUs for kyphoplasty. The ACR is pleased to work with other stakeholders and the AMA RUC on the development of non-facility RVUs for the kyphoplasty codes 22523, 22524, and 22525. These inputs will be presented to the RUC in September of 2011.

***Ultrasound Equipment***

The ACR agrees with the CMS proposal asking the RUC to review inputs and prices for ultrasound equipment. We will work closely with the RUC to assist in addressing any inconsistencies in the direct PE database.

***Payment for Bone Density Tests (DXA)***

In 2012, CMS is proposing that the payment for dual-energy x-ray absorptiometry (DXA) be resourced-based rather than based on imputed RVUs and this year’s conversion factor. As a result, the work values and practice expense values for DXA will be lower in 2012. In addition, DXA will be subject to the implementation of the radiology PPIS data as calculated in the practice expense methodology. The results of these changes are shown in the table below. In addition to the concerns about the severe cuts, there is also the concern of what would happen to the payment of DXA and other codes if Congress does not override the mandated cuts in the conversion factor (CF). Many of the payment rates would move close to zero. As you can see in the table below, it would leave DXA professional component rate at \$6.95 and would cut the technical component by almost two-thirds to \$32.83. This preventative service cannot be provided at the 2012 payment level even with a stable CF, much less at a lower CF rate. This is a clear example of the potential ramifications of a flawed sustainable growth rate formula and flawed radiology PPIS data.

Code	Description	2011 Pay	2012 Pay	% Change in RVUs for 2012	Proposed % Change in Payment	Change Payment Rate with Cut in CF	% Change in Payment Rate with Cut in CF
77080	DXA bone density, axial	\$97.51	\$56.40		-42.2%	\$39.87	-67.9%
77080-26	DXA professional component	\$10.87	\$9.85	-13%	-9.4%	\$6.95	-36.1%
77080-TC	DXA technical component	\$86.64	\$46.55	43.8%	-46.3%	\$32.83	-62.1%



The agency notes that the Affordable Care Act authorizes the Secretary to enter into a study with the Institute of Medicine of the National Academies to look at the ramifications of Medicare payment reductions for DXA over a three-year period from 2007 – 2009, but adds, without further explanation, that this study has not yet been conducted. The ACR urges CMS to conduct this study very soon and to expand its review to include impacts out to 2013.

CMS requests RUC review of the DXA CPT codes, 77080 and 77082. The ACR will work closely with the RUC review of these codes.

### **Physician Quality Reporting System (PQRS)**

#### ***Group Practice Reporting Option***

CMS is proposing to change the definition for a “group practice” for purposes of PQRS to 25 or more physicians as opposed to 2 or more physicians as in 2011. We recognize that CMS is moving to this proposed revision due to the lack of GPRO II participants and to align the PQRS group practice definition with other Medicare programs involving group practices. However, as the penalties for non-participation in PQRS approach, more and more physicians will want to participate and to report their data as a group rather than as individuals. We believe this is particularly important if CMS moves towards opening the GPRO option for specialist care – beyond the current focus on primary care – and begins more often to include measures that permit different levels of reporting (i.e., individual or group) for different purposes such as team-based care or care coordination. Additionally, some measures addressing important topics may not have sufficient sample size to calculate valid rates for individual physicians. This type of measure lends itself to the GPRO approach. **Therefore, we recommend that CMS retain the opportunity for groups of fewer than 25 physicians to participate in the PQRS GPRO option.**

#### ***EHR-Based Reporting***

CMS is proposing for 2012 and beyond to allow physicians and other eligible professionals (EPs) who participate in the PQRS via the employee health record (HER)-based reporting mechanism to have the option of submitting quality measure data obtained from their PQRS-qualified EHR to CMS either directly from the EP’s qualified EHR or indirectly from a qualified EHR data submission vendor on the EP’s behalf. Physicians and other EPs would be required to have a separate PQRS-qualified EHR product, despite the fact that physicians and other EPs may have already purchased Certified EHR Technology for purposes of reporting under the Medicare and Medicaid EHR Incentive Programs, *i.e.*, meaningful use (MU) program. Physicians have invested significant amounts of money in purchasing Certified EHR Technology for the Medicare and Medicaid EHR Incentive Programs. **Physicians should not have the added burden of verifying whether their current EHR**



**technology is also qualified for purposes of reporting under the 2012 PQRS -- in fact, just understanding the difference between a PQRS-qualified EHR and an EHR data submission vendor is a task in itself.**

### *Proposed 2012 PQRS Quality Measures and Measures Groups*

#### Individual measures

CMS is proposing 26 new individual measures. The ACR supports inclusion of the 3 breast cancer measures from American Society of Breast -- Image Confirmation of Successful Excision of Image-Localized Breast Lesion; Preoperative Diagnosis of Breast Cancer; and Sentinel Lymph Node Biopsy for Invasive Breast Cancer.

#### Measures Groups

CMS states that one criterion used for including measures as a measures group is to reflect the services furnished to beneficiaries by a particular specialty. The ACR recognizes that CMS may have proposed the following Radiology measures as a measures group for that reason:

- 1) Reporting to a Radiation Dose Index Registry
- 2) Cumulative Count of Potential High Dose Radiation Imaging Studies: CT Scans and Cardiac Nuclear Medicine Scans
- 3) Utilization of a Standardized Nomenclature for CT Imaging Description
- 4) Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules According to Recommended Guidelines
- 5) Overuse: Abdomen, Pelvis or Combined Abdomen and Pelvis CT Studies
- 6) Equipment Evaluation for Pediatric CT Imaging Protocols
- 7) Utilization of Pediatric CT Imaging Protocols
- 8) Search for Prior Imaging Studies Through a Secure, Authorized Media-Free Shared Archive
- 9) Images Available for Patient Follow-up and Comparison Purposes
- 10) Exposure Time Reported for Procedures Using Fluoroscopy

First, the ACR fully supports the inclusion of a Radiology measures group in theory; however, a number of measures in this proposed group have different denominators, and an eligible professional (EP) would not be able to report all the measures in the group.



Since CMS states in the proposed rule that if an EP reports a measure contained within a measures group with a zero percent performance rate, the EP will fail to meet the criteria for the satisfactory reporting of measures groups. If denominators for measures within a measures group differ, an EP may not have an opportunity to report on all measures in the group, and it would be inequitable for physicians to be deemed to have unsatisfactory reporting on the measures group.

Second, the ACR strongly supports the future inclusion of these measures in PQRS, and will continue to work with the measure developers and CMS on readying the measures for adoption.

Third, at such time that a valid Radiology measures group is proposed, the ACR strongly urges CMS to make the measures available as either a measures group OR as individual measures to increase the potential number of radiologists who report these measures. **Additionally, making any newly proposed Radiology measures available as individual measures would enable many more radiologists to registry report, since the likelihood of any radiologist being able to report three measures would increase.**

We also advocate that these measures be reportable via claims-based reporting OR registry-based reporting. There is no guarantee that a registry will pick up new measures, and if not, then radiologists will not be able to report on these measures if designated for registry reporting only. At least for the first year of reporting, or until such time that there is an available registry to report the measures, an EP should have the option of claims-based reporting.

Additionally, the ACR does not believe the two pediatric measures (#6 and #7 above) are appropriate for PQRS since the denominator population would not be, for the most part, Medicare-eligible patients.

The ACR would like to point out to CMS that there are two versions of the "Participation in a Dose Index Registry" measure named in the CMS 2012 proposed list. There is an ACR measure, which is based on automated data collection and reporting to a registry such as the ACR Dose Index Registry. The ACR Dose Index Registry allows imaging facilities to track, compare and lower radiation from CT scans, helping imaging providers gauge how effective their dose optimization efforts are by continuously supplying a measurement of their dose over time. At the national level, it provides a big picture view of how dose reduction policies are working in the clinical setting. In 2011, the ACR submitted this measure to the National Quality Forum for endorsement, prior to the formation of the ABMS/ABR/ACR/AMA PCPI workgroup on Radiation Dose Optimization, from which a second "Participation in a Dose Index Registry" was developed. The ABMS/ABR/ACR/AMA PCPI measure allows manual data collection and tracking. At this point in time, the ACR measure has tentatively gained NQF endorsement, with NQF Board approval pending. **We urge CMS to consider keeping the Participation in a Dose Index Registry (ACR version) in PQRS 2012 as an**



**individual measure, and also strongly urge CMS to consider using the ACR measure in the Hospital Outpatient Quality Reporting Program.**

#### Maintenance of Certification Program Incentive

**The ACR supports CMS' proposal to more broadly interpret the "more frequently than is required" standard for successful participation in a Maintenance of Certification (MOC) program.** Specifically, in meeting the "more frequently" standard to be eligible for the additional PQRS incentive payment of 0.5 percent, an EP would be required to "more frequently" meet at least one element of an MOC program, as determined by the MOC, rather than meet all elements of the MOC program more frequently than is required. This broader interpretation is more consistent with the statutory intent and will allow EPs more flexibility in meeting this standard.

#### Interim Feedback reports

In addition to the feedback report that participants receive at time of incentive issuance, CMS proposes to provide a "simplified" interim feedback report in the summer of the program year, based on claims data from January 1 to March 31 of that program year. The interim report will be for professionals reporting individual or measures groups, as opposed to only measures groups, as is the case for 2011.

**The ACR applauds CMS' proposal to provide interim feedback reports for the claims-based reporting mechanism under the PQRS for 2012 and beyond.** Currently, incentive payments and feedback reports are distributed seven or eight months after the reporting period has ended. This lag time makes it difficult for physicians to improve their understanding of program criteria or participation and respond during the period to which the feedback reports apply. The proposed interim reports will alert physicians to potential problems in their PQRS reporting and enable them to revise and correct their reporting practices, if needed, to be a successful participant. This is particularly important for claims-based reporting, as experience has shown the success rate is much less for that method of reporting.

#### e-Prescribing (eRx)

The e-Prescribing requirements for reporting exclude radiologists from the penalty (and current incentive), but there are some interventional radiologists and radiation oncologists that may be subject to the adjustment, based on the specifications of the e-Prescribing. The addition of the several exemption categories, in particular the "limited prescribing activity" exemption, should remedy the problem for the affected radiologists. **The ACR supports the exemption categories and commends CMS for allowing a process for exemption requests on a case-by-case basis given that physicians have varying practices.**



### Physician compare website

The Affordable Care Act required CMS to develop a Physician Compare website by January 2011. CMS has added a "compare" function to the Medicare Physician Directory website as an initial step. CMS has posted names of EPs who satisfactorily submitted data for 2009 PQRS, and intends to do the same for 2010 PQRS participation later this year.

The ACR encourages CMS to be specific and clear in posting the information that successful reporting is just that – successful reporting – and does not necessarily indicate that higher quality care was or will be provided by those individuals who earned PQRS incentive payments. Further, the ACR encourages CMS to work with physician focus groups to ensure that the information on the Physician Compare website is accurate, and not subject to misinterpretation.

### PQRS EHR incentive pilot

In addition to allowing attestation for 2012 payment year, CMS proposes to establish a pilot mechanism for reporting Clinical Quality Measures (CQMs) electronically. Participation in the PQRS-EHR Incentive pilot would be voluntary as an alternative to attestation for 2012.

The ACR understands that this pilot will allow CMS to gain experience with collecting quality measurement data directly from an EHR, as well as an EHR vendor. This experience is essential to better understand and improve upon the functionality of electronically capturing quality data. **However, for this pilot to be successful for both physicians and the Medicare program, CMS must further clarify the requirements of this new pilot.** We support efforts to integrate these two programs, but the technology and processes by which physicians report on CQMs to qualify for both programs must be more intuitive and adaptable for a diverse number of physician offices. Moreover, as mentioned in comments on EHR reporting, the burden of two separate technology certification requirements for PQRS versus the EHR Incentive program creates barriers to those physician practices interested in pursuing robust electronic reporting of quality measures.

**We urge CMS to clearly state in the final rule how participation in the PQRS-Medicare EHR Incentive Pilot and the proposed PQRS EHR reporting option for 2012 will allow physicians to successfully satisfy the CQM reporting requirements for the EHR Incentive program and PQRS reporting requirements.**



### Physician feedback program – Confidential Feedback Reports

CMS states that the Physician Feedback Program in conjunction with the value-based payment modifier reinforces the goal to provide physicians with "fair, actionable and meaningful information concerning resource use and quality regarding their Medicare FFS patients" and in implementing value-based purchasing (VBP). As called for in the Patient Protection and Affordable Care Act (PPACA), information in the reports will be used to apply the value-based modifier to some physician payments in 2015 and to all physician payments by 2017.

CMS has stated that it will provide every Medicare practitioner with a "feedback" report, to include both "cost" and quality data, prior to implementation of the payment modifier.

CMS believes that attribution of beneficiary cost information is an important aspect of the program and that they must balance costs for delivered services within the physician's control and costs for services not in their control. CMS recognizes that attribution rules have the potential to alter incentives regarding how physicians coordinate and deliver care. Also, determination of valid comparison groups is complicated.

CMS is looking at alternative and broader attribution methods to allow more beneficiaries to be matched to physicians for quality of care and associated resources, i.e., based on evaluation and management services and minimum cost threshold. Cost of service rules may better apply to physicians who furnish common procedures, e.g., surgical or intervention. CMS plans to combine that with quality measures appropriate to practices of such specialists.

CMS also intends to look at stratifying physicians by specialty and conditions they treat; allowing cost and clinical measures to reflect procedures/services best portraying practice patterns. CMS also believes that Taxpayer Identification Number level reporting of cost and quality data may help with low volume of patients reported on by individual physicians.

**The ACR agrees with CMS that the issues outlined above must be addressed prior to implementation of the value-based payment modifier and Physician Compare reporting.** As we have stated previously, physician collaboration in developing valid and meaningful measurements and feedback reports for consultant or hospital-based specialties such as radiology, pathology, anesthesiology, and infectious disease is particularly essential. Attribution to these physician types in the current or planned structure and focus of the reports does not make sense. Since most services performed by radiologists and imaging providers are ordered by other health care providers on behalf of their patients, CMS must carefully consider how to attribute costs to radiologists. Radiologists cannot always control utilization, but they do routinely make decisions about the appropriateness of tests and their subsequent utilization for specific patients. Measuring this contribution is difficult since tests not performed are never seen by the



Medicare program. **Specialties that are focused on diagnostic medicine pose particular challenges in the Confidential Feedback Program, and in the end, devising an attribution for credible feedback reports and valid comparison groups for these specialties may be impossible. If so, CMS should inform Congress that this is the case and recommend modifications in the PPACA's value-based modifier requirements.**

### **Conclusion**

Thank you for the opportunity to comment on the important issues discussed in this proposed rule. We are gravely concerned about the impacts these proposals and future proposals will have on the viability of radiology offices and imaging centers, which also could have negative effects on access to affordable quality care for patients especially in rural communities. If you have any questions about our comments please feel free to contact Maurine Dennis at 800-227-5463 ext. 4559 or via email at [msdennis@acr.org](mailto:msdennis@acr.org).

Respectfully Submitted,

A handwritten signature in black ink that reads "Harvey L. Neiman, MD".

Harvey L. Neiman, MD, FACR  
Chief Executive Officer

cc: Ken Simon, MD, CMS  
Amy Bassano, CMS  
Chris Ritter, CMS  
Ken Marsalek, CMS  
Elizabeth Troung, CMS  
Bibb Allen, Jr., MD, FACR, Chair, ACR Commission on Economics  
Geraldine B. McGinty MD, Vice-Chair, ACR Commission on Economics  
Maurine S. Dennis, ACR  
Angela J. Kim, ACR