



July 25, 2011

Donald Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1582-PN  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule; Proposed Notice**

Dear Administrator Berwick:

The American College of Radiology (ACR), representing over 34,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, is pleased to submit comments on the proposed notice "Five-Year Review of Work Relative Value Units under the Physician Fee Schedule" published in the Federal Register on June 6, 2011. We will address the work value for codes 47000 (needle biopsy of liver), 36247 (place catheter in artery), 22521 (percutaneous vertebroplasty, lumbar), 22523 (percutaneous kyphoplasty, thoracic), 22524 (percutaneous kyphoplasty, lumbar), and 78264 (gastric emptying study). We will also comment on the Centers for Medicare and Medicaid Services' (CMS') use of data from the physician practice information survey (PPIS) to calculate indirect expenses.

**General Comments**

The ACR is very concerned with an apparent lack of transparency in CMS' decision making process. The specialty societies involved in the five-year review process expended significant resources in surveying and evaluating the relativity of these services within the Resource-Based Relative Value Scale (RBRVS). The work values recommended by the specialty societies were vetted by the Relative Value Scale Update Committee (RUC). When CMS disagreed with the RUC's recommendations, it did so without providing a specific rationale for lowering the work values for many of the codes. The ACR asks that CMS be more transparent in its decision making process and provide a rationale when in disagreement with the RUC's recommendations. For codes 47000, 36247, 22521, 22523, 22524, and 78264, the ACR requests that the RUC recommendations be maintained.

**47000: Needle Biopsy of the Liver**

CMS listed code 47000 on the list of codes referred to the CPT Editorial Panel for consideration of coding changes, and stated that the work value was not addressed during the five-year review. The ACR believes that this is an error. This code was sent back to CPT but only to add conscious sedation, which the surveys deemed typical. The ACR and the Society of

Interventional Radiology (SIR) submitted a work recommendation to the RUC of 1.90 RVUs, which was accepted by the RUC and subsequently recommended to CMS. The ACR requests that CMS implement this value of 1.90 RVUs for code 47000 beginning January 1, 2012.

**36247: Place Catheter in Artery**

The American Medical Association's (AMA) RUC accepted the survey median work value of 7.00 for code 36247. In the rule, CMS states that they disagree with the RUC and believe that the current work value of 6.29 should be maintained. The RUC determined that there is compelling evidence to increase the work value for this code as the patient population has changed. The work for 36247 will increase as this code will no longer be reported with the lower extremity revascularization services. The remaining patients for whom 36247 will be used are more difficult and require the increased work reflected in the RUC's recommendation. For example, procedures now reported with 36247 would include catheterization of the mesenteric vessels and renal vessels (as exemplified by the vignette), which are inherently more complex. The caliber of the mesenteric and renal vessels is smaller than the iliac and superficial femoral arteries, and the end-organs are more susceptible to the complication of thrombo-embolic injury. Catheterization of second and third order branches of the mesenteric vasculature has a definite higher failure rate than the first order catheterizations reflecting the incrementally more difficult nature of this work.

In the rule, CMS states that they agree with the change in the global period from a 90 day to XXX. The ACR believes this to be an error since the specialty societies actually requested that the global period be changed from XXX to 000, a change which was granted during the survey process. We ask that the global period for code 36247 be correctly listed as 000 and not XXX.

The ACR asks that code 36247 be assigned a work value of 7.00 and the global period be changed to 000, as recommended by the RUC. The ACR supports the additional comments submitted by the Society of Interventional Radiology and the RUC.

**22521: Percutaneous Vertebroplasty Lumbar**

**22523: Percutaneous Kyphoplasty, Thoracic**

**22524: Percutaneous Kyphoplasty, Lumbar**

In the rule, CMS states that codes 22521, 22523, and 22524 services were previously valued based on one full discharge management day and not the half discharge management day reflected for the other codes in this family. Accordingly, CMS proposes to back out the work value associated with a half discharge management day (.64 RVU) and reduce the work value for 22521 from 8.65 to 8.01, for 22523 from 9.26 to 8.62, and for 22524 from 8.86 to 8.22.

The ACR disagrees with CMS' proposal to reduce the work values for the three codes mentioned above. During the 2010 five-year review, the specialties involved clearly showed that the work value for all codes in the vertebroplasty and kyphoplasty family were based on the patient being discharged on the same day (i.e., only half discharge management day). We clearly showed that

a clerical entry error into the RUC database had occurred which inadvertently reflected that a full discharge management day was included. Therefore, the original values, derived by magnitude estimation, are still correct. CMS asserts the typical survey responses recommended full day discharges; however, that was not what the societies recommended, as the recommendations were changed. All of the presenting specialties have attested and documented that the original presentations were with only half-day discharge management services associated.

The ACR is also concerned that rank order anomalies are now present in this family of codes. Specifically, thoracic vertebroplasty, CPT code 22520 (Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; thoracic with work value of 9.22) will now be valued higher than thoracic kyphoplasty, 22523 (proposed CMS RVU – 8.62). This rank order implies that vertebroplasty is more work than kyphoplasty, which is not the case, and contradicts the rank order of these two services in the lumbar spine. The ACR requests that CMS not back out the work associated with a half discharge management day from codes 22521, 22523, and 22524, and accept the values recommended by the RUC.

#### **78264: Gastric Emptying Study**

The RUC recommended the survey median work value of 0.95. However, CMS disagrees with the RUC and believes that the 25<sup>th</sup> percentile survey data is more appropriate based on its similarity in the physician work to other diagnostic tests. We believe this reduction is arbitrary and do not understand to which “diagnostic tests” the comparison was made. The ACR and the Society of Nuclear Medicine (SNM) submitted a joint recommendation to the RUC based on the random survey of nearly two thousand physicians. The RUC reviewed the survey results from 168 respondents. We provided compelling evidence that there has been change in technology as the protocol to perform code 78264 has been standardized. The procedure is different than it was 20 years ago, and the Harvard methodology was flawed as it used extrapolation to determine physician time and the work RVU. The new guideline, standardized in 2009, standardized the radiolabeled meal, the preparation of the patient, the acquisition and processing of the imaging data, and the interpretation criteria. The preparation of the patient requires a standard patient questionnaire, assessment of the patient’s glucose level, assessment of the patient’s current medications to avoid an adverse reaction, and determining a woman’s menstrual cycle. The standardized procedure now requires that the interpreting physician be certain that there was or was not >90% gastric emptying of the radiolabeled meal by four hours. Additionally, the interpretation is more complex requiring both greater knowledge of the clinical conditions leading to the procedures as well as the limitations and causes of errors in the results. The RUC accepted our compelling evidence arguments.

The RUC found that 78264 compares favorably to the key reference service 78707 (Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention) with .96 RVUs. Our recommendation also compared favorably to 78453 (Myocardial perfusion imaging, planar (including 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)), with total time of 20 minutes and 1.00

work RVUs. The RUC determined that the median work value of 0.95 appropriately maintained relativity among similar services.

The ACR supports additional comments submitted by SNM and the RUC. The ACR requests CMS accept the median work value of 0.95 for code 78264.

### **CMS' Practice Expense Methodology**

In the rule, CMS states that they have used the PPIS data to calculate the indirect practice expense values for the overall practice expense values for services under the physician fee schedule. The ACR believes that the PPIS data for radiology are grossly under-represented as reflected in the multi-specialty letter sent to CMS on March 31, 2011. As we iterated in the letter, the PPIS data for radiology are simply unrepresentative and their use unfair. Our analysis, however, has revealed methods through which the data could be made more representative of actual diagnostic radiology, interventional radiology, and nuclear medicine expenses.

Below are those methods, and we respectfully request that CMS comment on their progress in implementing them.

- Current PPIS data should be weighted to accurately represent radiology practices in order to adequately compensate for the expenses incurred in delivering radiology services to Medicare beneficiaries using the “2007 Survey of Radiologists: Practice Characteristics, Ownership and Affiliation with Imaging Centers.”
- Office-based practice data in the six main expense categories are under-reported in the PPIS sample for radiology practices. A minimal cost per hour (\$5.00 PE/HR) in each direct cost category should be used to define office-based practices, and the proportion that these practices represent should be set to 30%. This would increase the total PE/HR to \$162, a more representative figure.
- Nuclear Medicine has too few PPIS data points to adequately represent this medical profession. The results should be set aside and Nuclear Medicine should be cross-walked to the results obtained for Radiology.
- CMS should resurvey and replace current PPIS data with stratified PPIS data by CY 2013.
  - Stratify the survey sample by non-hospital and hospital practice settings and blend based on distribution of volume.
  - Allow collection of more accurate practice cost data of physician practices in different settings.

- At the request of the American Society for Radiation Oncology (ASTRO), CMS accepted stratified data for radiation oncology and should do the same for diagnostic radiology.
- The PPIS data for radiology should be collected at the practice level (not the individual physician level), as previously recommended by The Lewin Group.
- Conduct a physician practice expense survey and update practice expense data at least every three years.
- CMS should disclose all formulas that are used for calculating the PE/HR and revised practice expense RVUs to ensure transparency.

Flawed PPIS data cannot be the last word for valuing office-based radiology services, including imaging, nuclear medicine, and interventional radiology. With the impending evolution of new payment systems, such as Accountable Care Organizations, it is essential that practice expense methodologies be determined as accurately as possible. Inadequate representation of outpatient imaging expense will result in further closings of such facilities – which are already experiencing revenue pressures from other recent CMS decisions. This will result in diminished access to imaging services for Medicare beneficiaries. It will also result in adverse financial effects to that population, who will see higher cost-sharing effects when obtaining these services in non-office settings.

### **Conclusion**

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

Respectfully Submitted,



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