

## **Memorandum (August 19, 2010)**

TO: Pam Kassing, Maurine Spillman-Dennis American College of Radiology

FROM: Amanda Forys, Rachel Kramer, Kay Moyer, The Moran Company

SUBJECT: Analysis of the Multiple Procedure Payment Reduction Policy, 2006-2013

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After providing the ACR team with preliminary results of our analysis of the Multiple Procedure Payment Reduction Policy (MPPR) for diagnostic imaging services, a request was made for us to provide more detail on the impact of the proposed expansion of the MPPR as per the Affordable Care Act (ACA) and the proposals outlined in the NPRM for CY 2011. This memorandum responds to that request and also outlines additional findings from our analysis.

### **Highlights of our Analysis**

- From 2006-2013, we estimate that total losses in reimbursement due to the implementation of the MPPR policy are approximately \$1.2B.
- Accounting for further reductions due to the Deficit Reduction Act (DRA) (~\$400M)<sup>1</sup>, total losses for this set of imaging services are estimated to be approximately \$1.6B by 2013.
- Losses from 2010-2013 are a result of several policy changes:
  - Increasing the MPPR from 25% to 50%, beginning July 1, 2010, increases the 2010 estimated losses from \$49 million to \$98 million, an additional 50% reduction from prior levels.
    - We estimate losses from the 50% reduction policy alone to be \$193M in 2011, \$161M in 2012 and \$149M in 2013.
  - CMS proposes to expand the MPPR policy by applying it across diagnostic imaging families. We estimate that this proposal would increase losses for imaging services subject to the MPPR by an additional \$68M from 2011-2013.
  - Table 1 below outlines the estimated effect of various policies (e.g., increasing the MPPR reduction from 25 to 50%, removing diagnostic families, and applying the DRA cap to this set of services only) per year.
- As shown in Table 2, diagnostic Families 2 (CT and CTA-Chest/Thorax/Abd/Pelvis) and 5 (MRI/ MRA- Head/Brain/Neck) account for approximately 73% of total MPPR losses from 2006-2013.

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<sup>1</sup> The estimated \$400 million in losses due to the DRA reflects the set of services subject to the MPPR policy only and accordingly accounts for the interaction between the MPPR and DRA for this set of services. Our estimates suggest that full losses due to DRA imaging caps across all codes subject to the DRA policy reached \$2.6 billion over the first two years of the policy for which we also have corresponding SAF claims data (i.e. 2007 and 2008).

- As shown in Table 3, Diagnostic Radiology (DR) and Independent Diagnostic Testing Facilities (IDTF) are the two radiology specialties most affected by the MPPR policy. DR specialists incur approximately 50-55% of MPPR losses; IDTF approximately 20-21%.

## **Brief Background**

In 2006, CMS implemented the MPPR policy on the technical component (TC) of certain diagnostic imaging procedures. These procedures are grouped into 11 diagnostic families that reflect imaging services performed on contiguous body areas. Currently, the MPPR applies to TC only services and the TC portion of global services for imaging procedures performed within the same diagnostic family; however, the 2011 Proposed Medicare Physician Fee Schedule (MPFS) rule changes the MPPR policy to reduce procedures performed across diagnostic families.

Prior to July 1, 2010, CMS paid 100% of the TC reimbursement rate from the Physician Fee Schedule (PFS) for the highest paid procedure and reduced each additional procedure by 25%. Effective July 1, the reduction for each additional procedure was increased to 50% per section 3135(b) of the ACA. In addition, procedures reduced by the MPPR are also subject to additional reduced payments due to the DRA. The DRA caps payments for the TC portion of certain imaging services; these procedures are paid at the lesser of the PFS payment or the Outpatient Prospective Payment System (OPPS) payment.

Using the Medicare 5% Carrier Standard Analytic Files (SAF) for 2006-2008, The Moran Company (TMC) estimated the effect of the MPPR policy for imaging services from 2006-2013 (holding volume constant in out years), as well as additional losses in reimbursement due to the DRA capped payment rates for the set of imaging services subject to the MPPR policy.<sup>2</sup>

## **Results**

We identified all claims with at least one imaging code listed in the 11 diagnostic families identified with the implementation of the MPPR policy. From 2006-2010, approximately 18-19% of these claims contain multiple imaging services in the same diagnostic family and are subject to the MPPR policy (Table 1). This increases to 20% in 2011 as the MPPR policy is changed to affect all procedures across diagnostic families.

Total losses due to the implementation of the MPPR policy from 2006-2013 are estimated at \$1.2B. For codes subject to the MPPR policy, losses due to the DRA cap are approximately

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<sup>2</sup> Note: DRA losses presented here reflect reductions for the set of codes subject to the MPPR (see table 4) and do not include total losses that result when the DRA imaging cap is applied to the full set of services subject to the DRA policy.

\$400M.<sup>3</sup> Combined, these policies accounted for approximately \$1.6B in total losses for imaging services subject to the MPPR.

**Table 1: Estimate of Claims with Multiple Imaging Procedure Codes and Annual Losses, 2006-2013**

Year	Policy	Percent of Total Imaging			Total Losses (Millions)
		Claims Subject to MPPR Policy	MPPR Losses (Millions)	Additional DRA Cap Losses (Millions)*	
2006		18%	\$ 110.1	NA	\$ 110.1
2007		19%	\$ 116.4	\$ 126.3	\$ 242.7
2008		19%	\$ 121.3	\$ 131.9	\$ 253.2
2009		19%	\$ 112.6	\$ 68.1	\$ 180.7
2010		19%	\$ 147.1	\$ 30.6	\$ 177.7
	January-June (25% Reduction)		\$ 49.0	\$ 15.9	\$ 64.9
	July-December (50% Reduction)		\$ 98.1	\$ 14.7	\$ 112.8
2011		20%	\$ 219.4	\$ 28.6	\$ 248.0
	50% Reduction		\$ 193.2	\$ 23.7	\$ 216.9
	Across Diagnostic Families		\$ 26.2	\$ 4.8	\$ 31.0
2012**		20%	\$ 182.7	\$ 3.8	\$ 186.4
	50% Reduction		\$ 161.0	\$ 3.5	\$ 164.5
	Across Diagnostic Families		\$ 21.7	\$ 0.3	\$ 22.0
2013		20%	\$ 168.4	\$ 1.5	\$ 169.9
	50% Reduction		\$ 148.6	\$ 1.4	\$ 150.0
	Across Diagnostic Families		\$ 19.9	\$ 0.1	\$ 19.9
<b>Total</b>			\$ 1,178	\$ 391	\$ 1,569

Sources: 2005-2008 5% Standard Analytic File, Medicare Part B Carrier Claims. Estimates have been weighted to reflect the entire Medicare population and includes all specialties delivering services in the non-facility setting. Physician payment and multiple procedure reduction data from the 2005-2008 final year Physician Fee Schedule RVU files published by CMS. DRA payment rates from Appendix A of the 2007-2011 OPSS-APC rate files (2012-13 use 2011 rate data). Conversion factor for 2011-2013 takes into account MEI adjustment factor of 0.921.

\* DRA cap losses include losses for all procedures on the claims subject to the MPR policy. This includes the first procedure (paid at 100%), and all subsequent procedures in the same diagnostic family (paid at 75%).

\*\*2012 estimates are based on a blend of PE RVUs from 2009 to 2013 to reflect full-implementation of PPIS data. 2009 values do not reflect the MEI adjustment that is present in 2013 PE RVUs; therefore, the 2012 estimates may be underestimated.

As shown in the above table, increasing the MPPR from 25% to 50%, beginning July 1, 2010, reduces Medicare payment for imaging services by an additional 50%. MPPR losses projected for 2010, assuming a 25% reduction through June 30th, are estimated to be \$49M; with the additional reductions taking effect July 1, 2010, losses are projected to increase to \$147M. In addition, assuming constant volume, losses projected in 2011 would be \$193M, \$182M in 2012 and \$149M for 2013.

CMS proposes to remove the diagnostic families of services to which the MPPR currently applies. This proposal would increase losses for imaging services subject to the MPPR an

<sup>3</sup> This includes the DRA reductions for the first procedure reimbursed at 100% of the rate as well as all subsequent procedures reduced by the MPPR policy on the claim.

additional \$68M from 2011-2013. Increasing the MPPR reduction to 50%, removing diagnostic families, and applying the DRA cap is estimated to reduce payments for these services by \$248M in 2011, \$186M in 2012 and \$170M by 2013 as these values are fully transitioned.

#### *Losses by Diagnostic Family*

With the implementation of the MPPR, three diagnostic families incurred the most significant losses from 2006-2013:

- Diagnostic Family 2: CT and CTA (Chest/Thorax/Abd/Pelvis) represented 66-69% of procedures subject to the MPPR policy and incurred 59-61% of annual losses;
- Diagnostic Family 5: MRI and MRA (Head/Brain/Neck) comprised 8-9% of procedures reduced by the MPPR and 15-18% of annual MPPR losses; and
- Diagnostic Family 6: MRI and MRA (spine) contained 6-10% of procedures reduced by the MPPR and accounted for 8-10% of annual losses.

While the 2011 Proposed MPFS changes the MPPR policy to reduce reimbursement for multiple services across diagnostic families, this does not change the overall effect of reductions by diagnostic family (Table 2).

Table 2: Annual MPPR Losses by Diagnostic Family, 2010-2013

		2006			2007			2008			2009		
Diagnostic Family	Diagnostic Family Description	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses
01	Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical)	12%	\$ 2.6	2%	11%	\$ 5	2%	11%	\$ 6	2%	11%	\$ 3	2%
02	CT and CTA (Chest/Thorax/Abd/Pelvis)	66%	\$ 67.6	61%	68%	\$ 146	60%	69%	\$ 149	59%	69%	\$ 99	55%
03	CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	2%	\$ 1.8	2%	2%	\$ 7	3%	2%	\$ 8	3%	2%	\$ 5	3%
04	MRI and MRA (Chest/Abd/Pelvis)	2%	\$ 3.2	3%	1%	\$ 5	2%	1%	\$ 5	2%	1%	\$ 5	3%
05	MRI and MRA (Head/Brain/Neck)	8%	\$ 16.8	15%	7%	\$ 44	18%	6%	\$ 45	18%	6%	\$ 35	19%
06	MRI and MRA (spine)	6%	\$ 11.3	10%	6%	\$ 19	8%	6%	\$ 22	9%	6%	\$ 19	11%
07	CT (spine)	1%	\$ 0.6	1%	1%	\$ 1	0%	1%	\$ 1	0%	1%	\$ 1	0%
08	MRI and MRA (lower extremities)	3%	\$ 4.1	4%	3%	\$ 10	4%	3%	\$ 11	4%	3%	\$ 8	4%
09	CT and CTA (lower extremities)	0%	\$ 0.3	0%	0%	\$ 1	0%	0%	\$ 1	0%	0%	\$ 1	0%
10	Mr and MRI (upper extremities and joints)	1%	\$ 2.0	2%	1%	\$ 6	2%	1%	\$ 6	2%	1%	\$ 4	2%
11	CT and CTA (upper extremities)	0%	\$ 0.0	0%	0%	\$ 0	0%	0%	\$ 0	0%	0%	\$ 0	0%
<b>Total</b>			<b>\$ 110</b>		<b>\$ 243</b>			<b>\$ 253</b>			<b>\$ 181</b>		

  

		2010			2011			2012			2013		
Diagnostic Family	Diagnostic Family Description	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses	% Total MPR Claims	Total Losses (\$Millions)	% Total Annual Losses
01	Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical)	11%	\$ 5	3%	11%	\$ 7	3%	11%	\$ 6	3%	11%	\$ 6	4%
02	CT and CTA (Chest/Thorax/Abd/Pelvis)	69%	\$ 102	58%	66%	\$ 134	54%	66%	\$ 105	56%	66%	\$ 97	57%
03	CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	2%	\$ 6	3%	6%	\$ 11	4%	6%	\$ 8	5%	6%	\$ 8	4%
04	MRI and MRA (Chest/Abd/Pelvis)	1%	\$ 4	2%	3%	\$ 8	3%	3%	\$ 5	3%	3%	\$ 4	3%
05	MRI and MRA (Head/Brain/Neck)	6%	\$ 33	18%	9%	\$ 36	14%	9%	\$ 23	13%	9%	\$ 20	12%
06	MRI and MRA (spine)	6%	\$ 15	9%	10%	\$ 32	13%	10%	\$ 24	13%	10%	\$ 22	13%
07	CT (spine)	1%	\$ 1	0%	2%	\$ 2	1%	2%	\$ 1	1%	2%	\$ 1	1%
08	MRI and MRA (lower extremities)	3%	\$ 7	4%	4%	\$ 11	5%	4%	\$ 7	4%	4%	\$ 6	4%
09	CT and CTA (lower extremities)	0%	\$ 1	0%	1%	\$ 1	1%	1%	\$ 1	1%	1%	\$ 1	1%
10	Mr and MRI (upper extremities and joints)	1%	\$ 4	2%	2%	\$ 6	3%	2%	\$ 4	2%	2%	\$ 4	2%
11	CT and CTA (upper extremities)	0%	\$ 0	0%	0%	\$ 0	0%	0%	\$ 0	0%	0%	\$ 0	0%
<b>Total</b>			<b>\$ 178</b>		<b>\$ 248</b>			<b>\$ 186</b>			<b>\$ 170</b>		

Source: 2005-2008 5% Standard Analytic File, Medicare Part B Carrier Claims. Estimates have been weighted to reflect the entire Medicare population and includes all specialties delivering services in the non-facility setting. Physician payment and multiple procedure reduction data from the 2005-2008 final year Physician Fee Schedule RVU files published by CMS. DRA payment rates from Appendix A of the 2007-2008 Final OPSS APC rate files.

\* Total annual losses includes DRA Caps in addition to MPR policy. Totals percentages may be > 100% because a small portion of claims (<1%) had two or more diagnostic categories on one claim. Therefore, the claims is counted only once, but all diagnostic families are included.

### Losses by Specialty

DR, Interventional Radiology (IR), Nuclear Medicine (NM), and Radiation Oncology (RO) combined accounted for 54-58% of annual losses due to the implementation of the MPPR policy. IDTF accounted for approximately one-fifth of losses, while other specialties (particularly urology, hematology/oncology, internal medicine, family practice, and medical oncology) accounted for 24-28% of losses (Table 3). DR alone was the single specialty with the most significant losses, incurring over 50% of the total MPPR annual reductions.

**Table 3: Annual MPPR Losses by Radiology Specialty, 2010-2013**

Specialty	2006			2007			2008			2009		
	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*
DR	54%	\$ 61.0	55%	53%	\$ 129.5	53%	51%	\$ 130.7	52%	51%	\$ 93.2	52%
IR	1%	\$ 1.5	1%	1%	\$ 3.1	1%	1%	\$ 2.8	1%	1%	\$ 2.0	1%
NM	0%	\$ 0.2	0%	0%	\$ 0.6	0%	0%	\$ 0.8	0%	0%	\$ 0.6	0%
RO	1%	\$ 1.0	1%	1%	\$ 2.1	1%	1%	\$ 2.3	1%	1%	\$ 1.6	1%
<b>All Imaging</b>	<b>56%</b>	<b>\$ 63.6</b>	<b>58%</b>	<b>55%</b>	<b>\$ 135.3</b>	<b>56%</b>	<b>53%</b>	<b>\$ 136.6</b>	<b>54%</b>	<b>53%</b>	<b>\$ 97.3</b>	<b>54%</b>
IDTF	18%	\$ 22.2	20%	18%	\$ 49.9	21%	17%	\$ 52.2	21%	17%	\$ 38.6	21%
All Other	26%	\$ 24.3	22%	27%	\$ 57.5	24%	29%	\$ 64.4	25%	29%	\$ 44.8	25%
<b>Total</b>		<b>\$ 110</b>			<b>\$ 243</b>			<b>\$ 253</b>			<b>\$ 181</b>	

  

Specialty	2010			2011			2012			2013		
	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*	% Total MPR Claims	Total Losses (\$millions)	% Total Annual Losses*
DR	51%	\$ 91.8	52%	51%	\$ 126.3	51%	56%	\$ 95.2	51%	56%	\$ 86.7	51%
IR	1%	\$ 2.0	1%	1%	\$ 2.7	1%	1%	\$ 2.0	1%	1%	\$ 1.8	1%
NM	0%	\$ 0.6	0%	0%	\$ 0.8	0%	0%	\$ 0.6	0%	0%	\$ 0.5	0%
RO	1%	\$ 1.7	1%	1%	\$ 2.5	1%	1%	\$ 1.9	1%	1%	\$ 1.8	1%
<b>All Imaging</b>	<b>53%</b>	<b>\$ 96.0</b>	<b>54%</b>	<b>53%</b>	<b>\$ 132.2</b>	<b>53%</b>	<b>59%</b>	<b>\$ 99.8</b>	<b>54%</b>	<b>59%</b>	<b>\$ 90.9</b>	<b>53%</b>
IDTF	17%	\$ 36.3	20%	22%	\$ 52.9	21%	22%	\$ 38.5	21%	22%	\$ 34.8	20%
All Other	29%	\$ 45.5	26%	20%	\$ 62.8	25%	20%	\$ 48.2	26%	20%	\$ 44.3	26%
<b>Total</b>		<b>\$ 178</b>			<b>\$ 248</b>			<b>\$ 186</b>			<b>\$ 170</b>	

Source: 2005-2008 5% Standard Analytic File, Medicare Part B Carrier Claims. Estimates have been weighted to reflect the entire Medicare population receiving services in the non-facility setting. Physician payment and multiple procedure reduction data from the 2005-2008 final year Physician Fee Schedule RVU files published by CMS. DRA payment rates from Appendix A of the 2007-2008 Final OPPS APC rate files.

## Methodology

The current MPPR policy applies to the TC (including the TC portion of the global) of a claim with two or more imaging procedures billed in the same diagnostic family, while the 2011 proposed MPPR reduces imaging procedures across diagnostic families. The procedure with the highest RVU is paid at the full reimbursement rate, and all subsequent procedures are paid at 75% of the standard reimbursement rate (50% as of July 1, 2010). Table 4 provides a list of all diagnostic families (as of 2010), and the codes that fall within each family.

### *MPPR Losses 2006-2008*

We identified claims in the 2006-2008 Medicare 5% Standard Analytic File of Part B Carrier claims with the multiple imaging procedures included in Table 4 and calculated total losses for the procedures subject to the MPPR policy using the annual RVU files published by CMS.<sup>4,5</sup> If claims were marked with a modifier 59, they were removed from the analysis.<sup>6</sup> In addition, a small selection of procedures (<1%) were billed with units greater than two. These were considered a coding error and were removed from the analysis.

MPPR losses were calculated as 25% of the annual fee schedule payment rate for the second and subsequent service in the same diagnostic family.<sup>7</sup> For global codes, only the TC portion of the payment was reduced by 25%.

### *MPPR Losses 2009-2013*

From 2006-2008, imaging volume remained relatively constant. Since the most recent claims data available are for 2008, we used these data and assumed constant volume to estimate 2009-2013 MPPR losses. We did, however, apply the applicable annual RVU files to calculate annual losses.<sup>8</sup> Transitional PE RVUs were used for 2011 and fully-implemented 2011 PE RVUs were used to estimate 2013 losses. For 2012, we blended 2009 transitional and 2011 fully-implemented PE RVUs to estimate 2012 values as new Practice Expense per Hour (PE/HR) data

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<sup>4</sup> Total payments include the sum of PE RVUs + MP RVUs, multiplied by the conversion factor for the appropriate year (as these procedures were the TC portion of the service, Work RVUs = 0.00). Total payments reflect national average payments, and are not adjusted for Geographic Practice Cost Indices (GPCIs).

<sup>5</sup> RVUs were extracted from the CMS fourth quarter annual RVU file (2005-2008d).

<sup>6</sup> Modifier 59 demarks a claim as having multiple procedures but during different sessions. Therefore, the MPPR policy does not apply. (<http://www.cms.gov/MLN MattersArticles/downloads/SE0587.pdf>)

<sup>7</sup> If a claim had multiple diagnostic families, we removed the highest RVU from each diagnostic family and calculated losses for all other procedures in each family.

<sup>8</sup> 2009 RVU file- 2009d; 2010 RVU file- 2010HCR; 2011-2013- used Addendum B from the 2011 Proposed MPFS.

are being transitioned into the payment system and CMS did not actually publish 2012 values with the recent proposed rule release.<sup>9</sup>

From 2006 through June 30, 2010, MPPR losses were calculated as 25% of the annual fee schedule payment rate for the second and subsequent service in the same diagnostic family. For July 1, 2010 through December 31, 2010, MPPR losses were increased to 50% for services in the same diagnostic family. For 2011-2013, we calculated losses as 50% for all multiple imaging procedures performed across diagnostic families.

#### *DRA Losses 2007-2013*

Additional 2007-2013 DRA losses for codes subject to the MPPR (see codes in Table 4) were calculated by comparing RVUs (converted to rates) assigned to each procedure through the PFS to the APC payment rates in the OPSS for the corresponding year. If a claim was subject to the MPPR, and had a DRA cap payment that was lower than the PFS payment rate, the difference in payments was calculated as a DRA loss. This loss was calculated for the first imaging procedure paid at 100% on the claim, as well as subsequent imaging procedures reduced by the MPPR.<sup>10</sup>

#### *Conversion Factor*

The conversion factors for 2006-2010 were extracted from the annual RVU files released by CMS. For 2010-2013, we used the most recently released 2010 conversion factor (\$36.0791) noting that this does not account for the 2.2% update in place until November 30th. To adjust for the Medicare Economic Index (MEI) update discussed in the 2011 proposed MPFS for 2011-2013, we multiplied the 2010 conversion factor used in this analysis by 0.921 (\$33.23).

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<sup>9</sup> 2012 estimates are based on a blend of PE RVUs from 2009 to 2013 to reflect full-implementation of PPIS data. 2009 values do not reflect the MEI adjustment that is present in 2013 PE RVUs; therefore, the 2012 estimates may be conservative estimates.

<sup>10</sup> DRA payment rates were calculated using the annual procedure-level APC rates from the Outpatient Prospective Payment System Rule (OPPS), Addendum B. For 2011-2013, the 2011 Proposed OPPS Addendum B was used to estimate DRA capped rates.

**Table 4: HCPCS Codes Subject to MPPR Policy, by Diagnostic Family, 2010**

Diagnostic Family	Diagnostic Family Description	HCPCS Description	Diagnostic Family	Diagnostic Family Description	HCPCS Description
1	Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical)	76604	5	MRI and MRA (Head/Brain/Neck)	70336
		76700			70540
		76705			70542
		76770			70543
		76775			70544
		76776			70545
		76831			70546
		76856			70547
		76857			70548
		76870			70549
		71250			70551
		71260			70552
		71270			70553
		71275			70554
		72191			72141
72192	72142				
72193	72146				
72194	72147				
74150	72148				
74160	72149				
74170	72156				
74175	72157				
75635	72158				
2	CT and CTA (Chest/Thorax/Abd/Pelvis)	70450	6	MRI and MRA (spine)	72125
		70460			72126
		70470			72127
		70480			72128
		70481			72129
		70482			72130
		70486			72131
		70487			72132
		70488			72133
		70490			73718
		70491			73719
		70492			73720
		70496			73721
		70498			73722
		71550			73723
71551	73725				
71552	73700				
71555	73701				
72195	73702				
72196	73706				
72197	73218				
72198	73219				
74181	73220				
74182	73221				
74183	73222				
74185	73223				
75557	73200				
75559	73201				
75561	73202				
75563	73206				
77058					
77059					
3	CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	70450	7	CT (spine)	72125
		70460			72126
		70470			72127
		70480			72128
		70481			72129
		70482			72130
		70486			72131
		70487			72132
		70488			72133
		70490			73718
		70491			73719
		70492			73720
		70496			73721
		70498			73722
		71550			73723
71551	73725				
71552	73700				
71555	73701				
72195	73702				
72196	73706				
72197	73218				
72198	73219				
74181	73220				
74182	73221				
74183	73222				
74185	73223				
75557	73200				
75559	73201				
75561	73202				
75563	73206				
77058					
77059					
4	MRI and MRA (Chest/Abd/Pelvis)	71550	8	MRI and MRA (lower extremities)	73718
		71551			73719
		71552			73720
		71555			73721
		72195			73722
		72196			73723
		72197			73725
		72198			73700
		74181			73701
		74182			73702
		74183			73706
		74185			73218
		75557			73219
		75559			73220
		75561			73221
75563	73222				
77058	73223				
77059	73200				
5	MRI and MRA (Head/Brain/Neck)	70336	9	CT and CTA (lower extremities)	73700
		70540			73701
		70542			73702
		70543			73706
		70544			73218
		70545			73219
		70546			73220
		70547			73221
		70548			73222
		70549			73223
		70551			73200
		70552			73201
		70553			73202
		70554			73206
		6			MRI and MRA (spine)
72142	73219				
72146	73220				
72147	73221				
72148	73222				
72149	73200				
72156	73201				
72157	73202				
72158	73206				
72125					
72126					
72127					
72128					
72129					
72130					
72131					
72132					
72133					
7	CT (spine)	72125	11	CT and CTA (upper extremities)	73200
		72126			73201
		72127			73202
		72128			
		72129			
		72130			
		72131			
		72132			
		72133			
		73718			
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73222					
73223					
73200					
73201					
73202					
73206					

Source: 2010hcr RVU file, released by CMS May, 2010