

January 4, 2005

Glenn M. Hackbarth, JD
Chair
Medicare Payment Advisory Commission
601 New Jersey Ave NW, Suite 9000
Washington, DC 20001

Dear Mr Hackbarth:

The American College of Radiology (ACR), which represents over 32,000 radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, applauds the in-depth analysis and the objective and astute draft recommendations presented by the Medicare Payment Advisory Commission (MedPAC) staff on December 10, 2004. These draft recommendations are designed to help achieve high-quality, appropriate utilization of diagnostic medical imaging in the Medicare system. The ACR has consistently placed a high priority on improving quality and safety for patients across the nation and strongly encourages MedPAC to finalize its draft recommendations that call for all diagnostic imaging providers to meet quality standards for imaging equipment, nonphysician staff, images produced, patient safety protocols, and increased training for physicians who bill Medicare for interpreting diagnostic imaging procedures.

The ACR encourages and supports the technological innovations and advances in diagnostic medical imaging, which have unequivocally improved the quality of health care while producing cost savings through less-invasive diagnostic techniques. The College appreciates MedPAC's support of the tremendous developments imaging has brought to patient care and shares MedPAC's concerns regarding the quality, safety, and costs associated with the dramatic rise in the volume of procedures utilizing high-cost diagnostic imaging modalities. The ACR commends your clear articulation of the underlying factors, which contribute to the escalating growth in diagnostic medical imaging, such as the availability of imaging "equipment getting smaller and less costly and being able to move into different settings," as well as the pressure that physicians may feel to offset the lost revenue associated with swelling medical liability insurance premiums and reduced reimbursement fees.

When combined with the above-mentioned compounding factors, placing advanced imaging modalities such as computed tomography (CT), magnetic resonance imaging (MRI), and positron emission tomography (PET) in physician offices creates a tempting financial incentive that may be hard to resist, and one that has the potential to jeopardize the solvency of the Medicare trust fund. According to data compiled for the ACR, congressional implementation of MedPAC draft recommendations 4 and 5 (see Attachment A) could save the Medicare program a minimum of \$2 billion to \$6 billion over 10 years (the analysis behind this cost savings has been provided to your staff). Moreover, the quality of care Medicare beneficiaries receive should improve significantly with the implementation of quality and safety requirements for medical imaging.

In this regard, the ACR fully supports MedPAC draft recommendation 6 (see Attachment A) to include nuclear medicine and PET procedures as designated health services (DHS) under the Ethics in Patient Referrals Act. Nuclear medicine procedures are proliferating dramatically, as one can see from analysis of Medicare's Physician/Supplier Procedure Summary (PSPS) Master File. In the future, new and exciting nuclear medicine technology will encompass fusion imaging. The first well-developed fused imaging technique to enter the marketplace is PET/CT imaging. This important technology allows for detection of lesions and precise identification of their location in a specific anatomic site in order to select and plan appropriate therapeutic interventions. With PET not protected under the DHS category and with CT already included in the category, it is not clear how the Centers for Medicare & Medicaid Services (CMS) will address incorporating this hybrid technology.

During the December 2004 meeting, MedPAC commissioners raised several other important issues, including questions about teleradiology and outsourcing of imaging exams of United States' patients for interpretation in foreign countries. In terms of international teleradiology, the commission must understand that CMS does not provide reimbursement for services, including teleradiology services, rendered outside the United States [42 USC § 1395y(a)(4)]; therefore, any final interpretation provided via international teleradiology cannot be billed to the Medicare program. While teleradiology has generally proven to be a valuable tool in providing access to timely, quality radiological interpretations, the ACR believes physicians who interpret images by teleradiology should meet or exceed standards specific to licensure and credentialing, which ensure proper exam oversight and accountability by the interpreting physician (see Attachment B). A full white paper on International Teleradiology (which will be published in a peer-reviewed journal this February) and the ACR Practice Guideline on Teleradiology have been forwarded to your staff.

Another concern raised by some other medical specialties suggests that the shift in the site of service from inpatient hospitals to physician offices has inflated the increase in imaging utilization. While the growth in in-office imaging was much more rapid than the overall growth, there is no evidence that this is simply a shift in site of service. Imaging procedures in Part B Medicare, measured in terms of number of procedures as well as professional component RVUs per 1000 beneficiaries, increased in both inpatient and office settings. As per the PSPS Master File, the 3-year growth in imaging per 1000 beneficiaries for the period 2000-2003, in *all* sites of service combined, was 17% (5.3% per year) in number of procedures and 26% (7.9% per year) in professional component RVUs (a full analysis of this data has been provided to your staff).

Furthermore, while patient convenience is important, access to high-quality, safe, appropriate care must be the highest priority for the United States' elderly population. The quality-and-safety-centered recommendations presented at the December 2004 MedPAC meeting are critical to this goal. The ACR questions whether patients receiving imaging services in the office of a nonradiologist physician truly receive a more convenient encounter. A preliminary analysis of the 2001 Medicare 5% physician Standard Analytical File reveals that, of all the imaging billed by nonradiologists, at most 3.1% of CTs and 2.58% of MRs were billed with an evaluation and management code on the same day. Therefore, based on available data, in approximately 97% of the cases of imaging performed by nonradiologist physicians, there is no "same-day" convenience for the patient in having the CT or MR done in the office of the referring physician. Perhaps a more precise analysis on this matter could be conducted by Medicare officials, who

would have access to fully identified Medicare files that are now restricted to the public as a result of privacy regulations.

Patient convenience is also secondary to appropriate care in the private payer setting. For example, private payers often require precertification for coverage of certain procedures, including diagnostic medical imaging examinations. Because of the high costs associated with imaging utilization, these companies are determined to ensure that the appropriate examination is being prescribed for the appropriate reason. Such a requirement usually results in performance of the imaging exam on a date subsequent to the office visit—except in urgent cases.

Moreover, since the appropriate ordering of diagnostic medical imaging examinations is essential for quality care and a stabilization of these high costs, the ACR urges MedPAC to consider the use of Appropriateness Criteria™, which guide radiologists and ordering physicians to the most appropriate initial imaging examination. Since 1993, the ACR has recognized the need for appropriateness parameters for decision making in medical imaging and continually has advanced and expanded these clinical guidelines. The College has developed these evidence-based criteria for determining appropriate imaging examinations for the diagnosis and treatment of more than 190 specified medical conditions. It should be noted that the National Guidelines Clearinghouse of the Agency for Healthcare Research and Quality recognizes the ACR Appropriateness Criteria™.

It is also in the best interest of public health and safety as well as vital for the appropriate allocation of health care expenditures to require that diagnostic medical imaging procedures be performed by qualified health care providers and interpreted by qualified physicians. Accreditation, which evaluates the equipment specifications and calibration, dose (where appropriate), clinical image quality, physician and nonphysician personnel qualifications, and quality control protocols among other items, is one mechanism to help attain this goal.

The ACR's history of developing and administering accreditation programs that assess the quality of imaging facilities dates back to 1963 and is a testimony to the College's dedication to quality patient care in imaging and radiation therapy. While there may be some who believe that the important requirements associated with accreditation may be covered by state radiation protection programs, it must be understood that these programs vary by state and typically only evaluate the amount of radiation exposure and other equipment-related measures. State radiation protection programs do not evaluate the entire system in the way accreditation does.

Currently, the ACR has established and maintains 9 different accreditation programs, all with pathways for radiology and nonradiology practices to receive accredited status. For example, approximately 15% of the facilities accredited by the ACR in nuclear medicine are cardiology practices. The College is also ready and willing to collaborate with other specialty organizations in the development of our quality and safety resources. For example, the ACR Stereotactic Breast Biopsy Accreditation Program was developed in collaboration with the American College of Surgeons.

In conclusion, the volume of diagnostic medical imaging procedures being performed must be appropriate, and the costs associated with inappropriate volume must be contained. The policy developed by MedPAC staff is the best manner with which to accomplish this goal. The ACR

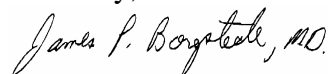
appreciates MedPAC's consideration of this important issue and is committed to working with the commission to facilitate the delivery of the highest-quality and safest care to Medicare beneficiaries.

The ACR is the premier organization with unmatched breadth, depth, and expertise in radiological sciences, medical imaging, radiation safety, radiation protection, dose delivery, and image interpretation. The College has demonstrated its commitment to evidence-based decision making in health care and dedication to high-quality, safe, and effective patient care through all of its available resources. The ACR shares your goal of quality imaging provided by individuals and facilities that can demonstrate they are qualified to perform and interpret these life-saving examinations.

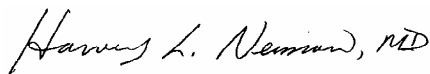
Please avail yourself of the ACR's invaluable expertise and experience. The ACR (and likely other credible accrediting bodies) is available to work with MedPAC, Congress, and CMS to establish these standards for the Medicare program.

If you have any questions or would find it helpful to have testimony from our members, please contact us at your earliest convenience. You may reach either of us through our staff, Rachel Kramer, at (800) 227-5463, ext 4559, or via email at rachelk@acr.org.

Sincerely,



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American College of Radiology



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At the December 10, 2004, Medicare Payment Advisory Commission (MedPAC) meeting, MedPAC staff presented a draft of recommended policy for commission consideration regarding strategies for managing the use of diagnostic medical imaging services in fee-for-service Medicare while ensuring access to appropriate care (there were 7 draft recommendations in total). The recommendations listed below are referenced in the preceding January 4, 2005, correspondence from the American College of Radiology (ACR) to the chair of MedPAC, Glenn M. Hackbarth, JD. These recommendations are consistent with ACR policy and must be adopted by the commission. The College strongly urges that the commission accept the following MedPAC staff recommendations:

4. The Congress should direct the Secretary to require that all diagnostic imaging providers meet quality standards for imaging equipment, non-physician staff, the images produced and patient safety protocols.
5. The Congress should direct the Secretary to develop standards for physicians who bill Medicare for interpreting diagnostic imaging procedures. The standard should be based on the training, education and experience required to interpret studies. The Secretary should have the authority to set less stringent standards in medically underserved areas.
6. The Secretary should include nuclear medicine and PET procedures as designated health services under the Ethics in Patient Referrals Act.

Statement on the Interpretation of Radiology Images Outside the United States

The ACR has become aware of several recent statements in the national and local media that promote outsourcing or sending of imaging exams of patients in the United States for interpretation in foreign countries. However, these statements have omitted a number of important conditions that are necessary to protect patients and to ensure the delivery of high-quality radiological care.

As the leading organization for medical radiology dedicated to ensuring quality patient care, the ACR is very concerned about the implications of overseas radiology and its potential effect on patient care in the United States. The ACR believes that physicians who interpret images by teleradiology should meet or exceed the same standards met by physicians practicing within the United States. Certification by the American Board of Radiology is the best means for the health care consumer to judge the qualifications of the radiologist. To achieve these standards, physicians who interpret images by teleradiology shall (1) be licensed to practice medicine in the state where the imaging examination is originally obtained, as well as possess any medical or other licensure required within the jurisdiction of the interpretation site; (2) be credentialed as a provider and maintain appropriate privileges in the health facility or hospital in the United States where the examination was obtained; (3) have appropriate medical liability coverage for the state in which the examination was obtained; and (4) be responsible for the quality of the images being interpreted. Physicians practicing outside the United States must willingly agree to submit to the jurisdiction of and be completely accountable to all applicable state and federal laws in the United States.

Radiology groups, hospitals, and other entities in the United States should enter into contracts for interpretation of imaging examinations provided from outside the United States with only those physicians who meet the foregoing criteria. Those criteria require that they possess the appropriate licensure, liability coverage, credentials, and hospital medical staff or other health care facility privileges.

Patients in the United States expect high-quality care and service from fully licensed and accountable medical practitioners. Patients also have the right to expect that all physicians who are providing their care, including radiologists, are practicing with a high level of skill and safety, as provided by meeting state licensure and hospital credentialing requirements. Patients also expect that their physicians will be subject to all state and federal laws governing the practice of medicine and held accountable for their actions. As physicians, we must insist that all physician services be held to the same high standards to ensure the absolute best for our patients.