



October 6, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Medicare Program; Hospital Outpatient Prospective Payment System and
CY 2007 Payment Rates; Proposed Rule**

Dear Dr. McClellan,

The American College of Radiology (ACR), representing 32,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists, appreciates this opportunity to comment on the proposed notice "Hospital Outpatient Prospective Payment System (HOPPS)" published in the *Federal Register* on August 23, 2006. We will address format of the proposed rule, Category III codes, brachytherapy procedural and seed payments, placement of positron emission tomography/computer tomography (PET/CT) codes, cost data for magnetoencephalography (MEG), hospital cost data and the threshold for bundling drugs and radiopharmaceuticals.

Format of the Proposed Rule

This proposed rule was released with proposed changes on two other payment systems (i.e., Ambulatory Surgical Center and Inpatient Prospective Payment Systems). Although the ACR understands that the changes to these payment systems are somewhat related, we are concerned that an important issue will be overlooked while sorting through the proposal. **The ACR recommends that Centers for Medicare and Medicaid Services (CMS) continues to publish the three payment systems in separate *Federal Register* notices.** However, if CMS decides to continue to combine these proposals, then **the ACR recommends that each proposal is tabbed separately for each payment system under the main proposal and not be intertwined.**

Category III CPT[®] Code Placements

The ACR has noticed that the eight category III CPT[®] codes (i.e., 0144T to 0151T) that were developed for coronary computed tomography angiography (CTA) and implemented on January 1, 2006 have been placed in regular Ambulatory Payment Classification (APCs) for cardiac imaging. The ACR believes that coronary CTA is a

new technology and the purpose of the development of the Category III codes was to determine how this study is typically performed and then to determine value. **The ACR recommends that CMS place the eight category III codes for coronary CTA into new technology APCs so that data can be collected and pricing can be determined prior to their assignment into permanent APCs.**

Code	Description	Current APC	Rate	New APC	Rate
0144T	CT heart wo dye; qual calcium	0398	\$261.66	1505	\$300.00
0145T	CT heart w/wo dye funct	0376	\$306.34	1505	\$350.00
0146T	CCTA w/wo dye	0376	\$306.34	1505	\$350.00
0147T	CCTA w/wo, quan calcium	0376	\$306.34	1505	\$350.00
0148T	CCTA w/wo, strxr	0377	\$415.12	1506	\$450.00
0149T	CCTA w/wo, strxr quan calc	0377	\$415.12	1506	\$450.00
0150T	CCTA w/wo, disease strxr	0398	\$261.66	1504	\$250.00
0151T	CT heart funct add-on	0282	\$95.72	1503	\$100.00

CMS proposes to accept the APC Panel’s recommendation to maintain the packaged status of code 0152T [computer aided detection with further physician review for interpretation, with or without digitization of films radiographic images; chest radiograph(s)]. **The ACR supports the APC Panel’s recommendation to pay this code separately when performed at a different site from the chest x-ray.**

Placement of Tumor PET/CT Codes

For 2007, CMS proposes to reassign tumor PET/CT codes 78814, 78815 and 78816 from New Technology APC 1514 to clinical APC 0308. The ACR has significant concerns regarding this proposal. First, the new PET/CT codes were effective January 1, 2005. This means that the CMS proposal to move these codes out of the new technology APC is based on relatively limited claims data. Second, the ACR does not support the proposal to place tumor PET and PET/CT codes into the same APC as the resources needed to provide PET and PET/CT procedures are different.

Accordingly, **the ACR supports the APC Advisory Panel’s recommendation to keep PET/CT in the new technology APC for one additional year to allow CMS to collect further data and recommends that CMS keep codes 78814, 78815 and 78816 in the New Technology APC 1514 at the payment rate of \$1,250.**

Code	Description	2006/ 2007 SI	2006 APC	2006 Payment Rate	2007 APC	2007 Payment Rate
78811	Tumor imaging (pet), limited	S	1513	1,150.00	0308	862.29
78812	Tumor image (pet)/skull-thigh	S	1513	1,150.00	0308	862.29
78813	Tumor image (pet) full body	S	1513	1,150.00	0308	862.29
78814	Tumor image pet/ct, limited	S	1514	1,250.00	0308	862.29
78815	Tumorimage pet/ct skull-thigh	S	1514	1,250.00	0308	862.29
78816	Tumor image pet/ct full body	S	1514	1,250.00	0308	862.29

Various New Codes on Stereotactic Radiosurgery

The ACR is aware that there are new CPT[®] codes for the services described by the G codes for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) which will become effective January 1, 2007. The ACR would like to request that CMS work with the specialty societies to develop appropriate crosswalks from the G codes to CPT[®] codes and the assignment of the new codes to APCs. This is vitally important to make sure that hospital coding, cost reporting and payment rates are consistent in the future.

Magnetoencephaolgraphy (MEG)

CMS proposes to accept the APC Panel’s recommendation to move the MEG codes 95965, 95966 and 95967 from new technology into clinical APCs. The ACR is concerned that this reassignment is based on few claims with highly variable costs and charges. MEG is beneficial in localizing abnormalities in patients with epilepsy and gives the surgeon a guide in order to perform seizure surgery with minimal loss of brain tissue. There are only limited number of sites in the country that offer this important procedure. The ACR is concerned that inappropriate payments will make this limited access even worse. **The ACR recommends that CMS work with the sites that provide MEG and consult with them on how to most accurately report their services. A few inaccurate claims could have a big impact on the hospital cost data from which the APC median is created.**

Code	Description	2006 APC	2006 Payment rate	2007 APC	2007 Payment rate
95965	Meg, spontaneous	1523	\$2,750.00	0038	\$3,155.27
95966	Meg, evoked, single	1514	\$1,250.00	0209	\$706.89
95967	Meg, evoked, each add'l	1510	\$850	0209	\$706.89

Recommendations on How Hospitals Can Better Report Their Costs

The HOPPS process does not strictly define a “cost center” and this creates the potential for wide variance in calculation of costs.

There is relatively little guidance or procedural rules for how hospitals should allocate fixed costs, particularly those of expensive imaging equipment, between inpatient and outpatient procedures.

There are also no consistent reporting requirements to identify an identical set of individual costs to be reported by each cost center.

In addition, there is little if any guidance for hospitals on how to update their chargemasters determining the relativity of charges among procedures. Accordingly, a hospital could be charging four to five times its cost for a long-established procedure while charging only 1.5 times its cost for a newer, more complex procedure. The resulting aggregate cost/charge ratio may well result in a severe undervaluation for the newer procedure, as is the case with chest CT angiography.

The ACR continues to remain concerned that hospitals do not report their costs in a consistent and accurate way nor do they update their charge masters regularly with charges that reflect appropriate relativity. **The ACR recommends that CMS develop a standard methodology that addresses all four of the above described deficiencies, and we offer to work closely with CMS in that process.**

Radiology Procedures

At the March 2006 meeting, the APC Advisory Panel made a recommendation that CMS review payments for computed tomographic angiography procedures to ensure that their payment rates are consistent and accurately reflect resources used. The ACR is concerned that the current OPSS methodology that applies historical cost to charge ratios to charges submitted by hospitals for a specific new technology creates an artificial reduction in the cost attributed to that technology and an inaccurate APC designation. The ACR recommends that CMS develop a more accurate methodology for calculation of true costs for new technology, independent of historical cost to charge ratios prior to 2001.

The ACR would like to discuss this further with CMS and determine how this can be accomplished.

Drugs and Radiopharmaceuticals

CMS set the threshold for establishing separate APCs for separate biologicals and drugs to \$50 per administration, which will expire by end of calendar year 2006. To determine the appropriate packaging threshold proposal for biologicals, drugs and radiopharmaceuticals for the CY 2007, CMS evaluated four options. CMS proposes to adopt the fourth option (update the packaging threshold for inflation). Accordingly, this proposal would increase the packaging threshold for radiopharmaceuticals from \$50 to \$55 for 2007, the same threshold that would apply to drugs and biologicals.

In sharp contrast, the APC Panel, at its August 2006 meeting, recommended that CMS eliminate the drug packaging threshold for all drugs and radiopharmaceuticals with HCPCS codes. **The ACR strongly supports this August panel recommendation.** The ACR is concerned that if radiopharmaceuticals and drugs are bundled in with the procedure, hospitals will not receive adequate reimbursement for them. Furthermore, we believe that drugs and radiopharmaceuticals reimbursed separately in a non facility setting should be treated the same in a facility setting.

Conclusion

Thank you for the opportunity to comment on this proposed rule. The ACR looks forward to continued dialogues with CMS officials. Should you have any questions on the items addressed in this comment letter, or with respect to radiology and radiation oncology, please contact Pam Kassing at 1-800-227-5463, ext. 4544 or via email at pkassing@acr.org.

Respectfully Submitted,



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