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September 24, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1717-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals -Within-Hospitals

Dear Administrator Verma:

The American College of Radiology (ACR), representing more than 38,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Hospital Outpatient Prospective Payment (HOPPS) and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.

The ACR provides comment on the following important issues:

1. Proposed Calculation and Use of Cost-to-Charge Ratios (CCRs)
2. Proposed APC Placement of New and Revised CY 2020 Category I and III CPT Codes
3. Proposed APC Placement of New CY 2020 Nuclear Medicine Codes New Technology Application
4. Proposed APC Placement of Cardiac CT CPT Codes
5. Proposed Change in APC Placement for CPT Code 0503T
6. Supervision Level for Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals

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Proposed Calculation and Use of Cost-to-Charge Ratios (CCRs)

Proposal

Beginning in CY 2020 CMS proposes to fully implement the CT and MR cost data regardless of the cost allocation method.

ACR Perspective and Comments

The ACR **requests that for the CY 2020 HOPPS final rule, that CMS set weights based on a single diagnostic radiology CCR—the same policy that CMS applied before it created separate CT and MRI standard cost centers in 2011.** The ACR makes this request based on evidence that the CCRs for CT and MRI data is flawed and are causing hospitals’ payments for CT and MRI services to be too low.

In February 2018, the ACR met with CMS officials and recommended the elimination of CT and MRI standard cost centers from both Inpatient Prospective Payment System (IPPS) and HOPPS and to return to the exclusive use of the diagnostic radiology CCR. The ACR makes this request because of evidence that the original intent for the CCRs for CT and MRI to help eliminate charge compression within the imaging APCs is not being met. The ACR has addressed our concerns in previous rulemaking comments.

Rationale for Separate Hospital Reporting of CT and MRI Cost Centers

CMS’ policy on this issue was raised in the FY 2009 HOPPS rule where it discussed “a contract [awarded] to the Research Triangle Institute (RTI) to study the effects of charge compression in calculating the relative weights and to consider methods to reduce the variation in the CCRs across services within cost centers.”¹ Charge compression describes higher percentage mark-ups on low cost items than high cost items. Using a single CCR that groups low and high cost items will result in underpayment of the high cost item and overpayment of the low-cost item. While RTI’s study was largely undertaken because of concerns about high cost medical devices being reported in the same cost center as low-cost supplies, RTI’s analysis went beyond that narrow issue.

For MRI and CT, the charge-compression hypothesis would set out to determine if higher cost diagnostic tests like MRI and CT have lower percentage mark-ups than lower cost X-ray tests. While MRI and CT scans are more expensive than traditional X-rays, the results of creating separate cost centers for them has produced the opposite result than would be expected—higher mark-ups for the more expensive services than the less expensive services. **As this result is the opposite of the hypothesis, the hypothesis is false.** However, it does not mean that the opposite is true—that MRI and CT have lower percentage mark-ups than other diagnostic X-ray tests. As the results are counter-intuitive, it makes more sense to conclude that how costs are reported to these costs centers is problematic than it does to conclude that CT and MRI are overvalued with a single radiology CCR.

¹ Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, Final Rule, August 19, 2008, page 48451.

Indeed, public comments acknowledged by CMS on this issue suggest the data is problematic:

The commenters believed that the CCRs for advanced imaging may reflect a misallocation of capital costs on the cost report. They further stated that this could indicate that many hospitals are reporting CT and MRI machines as fixed equipment and allocate the related capital costs as part of the facility's Building and Fixtures overhead cost center instead of reporting the capital costs directly in the Radiology cost center.²

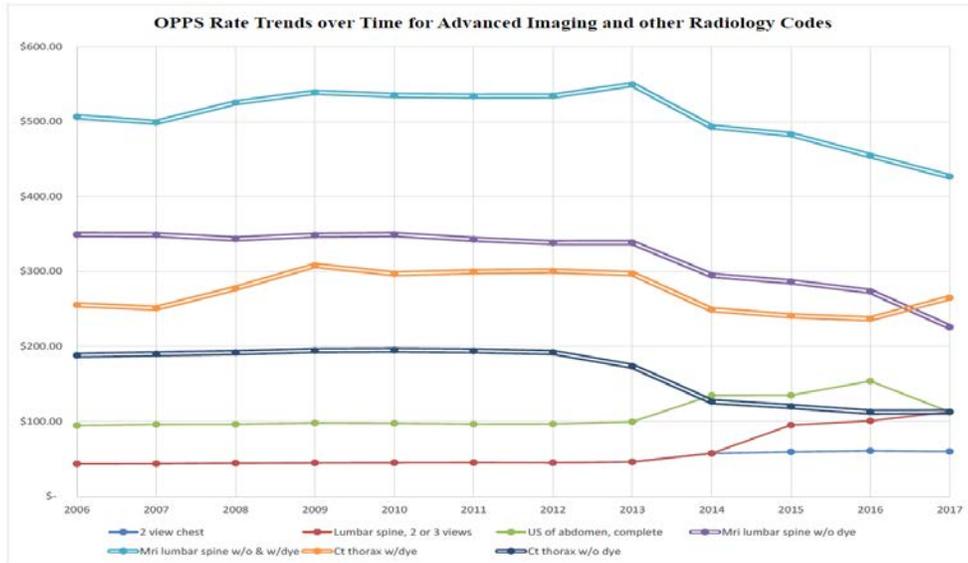
In responding to commenters' statements that hospitals would have problems with accurate creation of these new standard cost centers, CMS acknowledged that the allocation of very high cost "moveable equipment" to the department using that equipment, may not be a standard practice in hospitals. CMS recognized that such practice would not produce accurate CCRs and, it is for this reason that CMS delayed use of some hospital CCRs to set HOPPS rates until CY 2020.

Policy Impact of Separating CT and MRI Cost Centers

Figure 1 below illustrates the trajectory of selected single procedure HOPPS rates for advanced and non-advanced imaging procedures. The CCRs for CT and MRI cost centers are inaccurate and too low and are depressing the valuation of APCs that include CT and MRI. The rate in CY 2017 under the HOPPS for CT thorax w/o dye is now the same as that for an ultrasound of the abdomen complete and for an X-ray of the lumbar spine 2-3 views. These are all high-volume procedures, and advanced and non-advanced imaging are being paid at the same levels. Other high volume advanced imaging procedures have rates moving in the same direction. This pattern of payment does not fit the hypothesis of "aggregation bias" described by RTI based on 2007 data. On the surface, it does not make sense to pay the same for a CT as an ultrasound or an X-ray when a CT scanner is far more expensive than the ultrasound or X-ray equipment.

² FY 2009 IPPS Final Rule, page 48456.

Figure 1. Trends in Rates for Selected Imaging Procedures: Advanced and Non-Advanced



The Problem is Getting Worse, Not Better

In the chart below, we show the hospital level billing practices for selected CT and MRI claims. These data show that only about half of all hospitals paid under the HOPPS had CT and/or MRI cost centers that were reporting CCRs using the preferred methods (“dollar value” or “direct assignment”). Hence current rates have declined based on using partial data. **When all data are used for the CY 2020 it is unlikely that more hospitals will have changed their cost reporting to the method preferred by CMS.** Even if they did, the CCRs for CT and MRI using the other cost allocation methods also appear to be unreasonably low as we detail further below. In short, regardless of cost allocation method, separate CCRs and cost reporting for MRI and CT appear to be inaccurate.

The data in Chart 1 shows that hospitals have either been unable or unwilling to make the changes CMS regulations mandated.

HCPCS	Short Descriptor	Total Number of Hospitals	Number of Hospitals with MR or CT Cost Centers	Percent of Hospitals with MR or CT Cost Centers	Number of Hospitals with MR/CT Cost Centers Using Non-Square Footage Allocation Method	Percent of Hospitals with MR/CT Cost Center using Non-Square Foot Allocation Method	Geomean Cost of Total Hospitals	Geomean Cost of Hospitals with MR/CT Cost Centers Using Non-Square Footage Allocation Method	Percent Difference Between All Hospitals and Hospital Correctly Complying with CMS MR/CT Cost Center Billing
70553	Mri brain stem w/o & w/dye	2,926	2,020	69.0%	1,467	50.1%	\$ 380.51	\$ 335.76	-7.4%
71250	Ct thorax w/o dye	3,187	2,145	67.3%	1,541	48.4%	\$ 97.89	\$ 80.86	-21.1%
71200	Ct thorax w/dye	3,074	2,114	68.8%	1,519	49.4%	\$ 125.59	\$ 100.39	-25.1%
72148	Mri lumbar spine w/o dye	2,975	2,039	68.5%	1,472	49.5%	\$ 254.28	\$ 231.25	-10.0%

Notes

MRI Agents included in the analysis: A9575, A9576, A9577, A9578, A9579, A9581, A9583, A9585

CT Agents included in the analysis: Q9951, Q9953, Q9956, Q9957, Q9958, Q9961, Q9962, Q9963, Q9964, Q9965, Q9966, Q9967

Other allocation methods include dollar allocation and direct allocation.

Table 3 of the CY 2020 HOPPS proposed rule shows the CCRs that would be in use under the HOPPS if CMS uses all CCRs for the CT and MRI cost centers irrespective of the cost allocation method that the hospital is using. CT Scans have a CCR of 0.0359 and MRI is 0.0763.³ A CCR of 0.0359 suggests that hospitals are charging 27 times their costs for a CT exam. It is unreasonable to assume that this is correct. Further, ACR notes that this problem has become worse, not better since 2009. Although the number of valid CT and MRI CCRs has increased over time, they still would have a negative effect on the payment rates of almost all of the imaging APCs if all data regardless of cost allocation were used.

Table 3. CCR Statistical Values Based on Use of Different Cost Allocation Methods

Cost Allocation Method	CT		MR	
	Median CCR	Mean CCR	Median CCR	Mean CCR
All Providers	0.0359	0.0505	0.0763	0.1027
Square Feet Only	0.0290	0.0443	0.0665	0.0927
Direct Assign	0.0511	0.0609	0.0990	0.1197
Dollar Value	0.0432	0.0583	0.0879	0.1156
Direct Assign and Dollar Value	0.0433	0.0583	0.0886	0.1155

Furthermore, consistent with these findings, hospitals are unable to properly allocate indirect costs to an ancillary cost center comprised of capital equipment. The RTI study plainly stated this in the report:

“Charges and direct departmental costs are easy to recognize in the accounting records, but providers also need to capture indirect costs adequately by identifying separate allocation statistics. These particular services are very capital-intensive, and accurate cost ratios will depend on providers’ being able to assign actual equipment depreciation and lease costs directly to the cost centers, rather than the traditional method of allocating average capital costs based on square footage.⁴”

Excerpts from the RTI Report suggest the data has been problematic from the start:

“We were able to compute separately defined cost ratios for CT scanning in 25 percent of providers, and for MRI in 20 percent of providers, but in several of these the cost-to-charge ratios were so extremely low that it is likely that providers did not accumulate all of the costs, or possibly failed to identify allocation statistics to accumulate all of the indirect costs.⁵”

³ Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals, August 9, 2019, page 39408.

⁴ Whitehead, N., Kautter, J., Mosquin, P., Lynch, J., Squiers, L., Newman, L., . . . Coomer, N. (2008). Evaluation of the Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration (Rep.). Waltham, MA: RTI International. Pg. 65

⁵ Whitehead, N., Kautter, J., Mosquin, P., Lynch, J., Squiers, L., Newman, L., . . . Coomer, N. (2008). Evaluation of the Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration (Rep.). Waltham, MA: RTI International. Pg. 52

“Many facilities had very low cost ratios on these nonstandard lines, including many below 0.05. This raises questions about the relative accuracy of their cost finding.”⁶”

The analysis conducted by the ACR and our consultants, demonstrated that 51% of providers who have claims for CPT code 70450 had a CCR of less than 0.05. These claims made up 61% of rate setting claims. The table below shows providers with CCRs less than 0.05 for 10 radiology CPT codes.

HCPCS	Number of Providers with CCR <0.05	Total Providers	% of Providers	Number of Rate Setting Claims by Providers with CCR <0.05	Total Number of Rate Setting Claims	% of Rate Setting Claims
70450	1,589	3,099	51%	1,242,817	2,034,000	61%
74177	1,571	3,036	52%	214,189	379,876	56%
74176	1,580	3,065	52%	155,003	265,828	58%
71260	1,555	2,991	52%	133,304	244,597	54%
71250	1,582	3,085	51%	459,552	805,487	57%
72148	567	2,901	20%	79,962	425,628	19%
70553	557	2,841	20%	53,184	300,661	18%
70551	567	2,938	19%	50,212	252,687	20%
73721	558	2,839	20%	36,020	192,025	19%
74183	527	2,595	20%	19,737	119,119	17%

The requirement that hospitals create standard cost centers for CT and MRI is complex and hospitals are unable to respond. The CCRs for selected CT and MRI procedures show a significant number of CCRs that are close to zero. These near zero CCRs indicate that even when hospitals create standard cost centers, they are likely unable to accurately re-allocate many costs that are already allocated across hospital departments to new CT and MRI departmental cost centers. For these hospitals, the CCRs probably reflect allocations of staffing and dedicated departmental expenses, while the costs of equipment, some costs associated with space (e.g., lead in walls), other administrative costs have been spread across all hospital departments and have not been moved.

The presence of these near zero CCRs will contribute to underestimated costs used in rate setting, pulling rates for CT and MRI procedures down below their actual cost and further eroding payment accuracy. No other high cost technologies are treated in this manner. Hospitals have standard accounting practices for high cost moveable equipment and it is inconsistent and burdensome to expect hospitals to account CT and MRI in a different manner than they deal with other types of equipment. As CMS moves away from granular procedure specific payment mechanisms across payment systems, it is inconsistent to focus on CT and MRI treating them differently from all other technologies.

⁶ Whitehead, N., Kautter, J., Mosquin, P., Lynch, J., Squiers, L., Newman, L., . . . Coomer, N. (2008). Evaluation of the Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration (Rep.). Waltham, MA: RTI International. Pg. 65



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Square foot providers account for approximately 51% of the claims used in rate setting for the five CT codes and 48% of the claims used in rate setting for the five MR codes analyzed. The table below shows that for most of these codes, the average volume weighted cost is lower among square foot providers.

HCPCS	2020P Short Descriptor	Square Feet Providers	Direct/Dollar /Other Providers	Percent Difference in Weighted Average Cost
		Weighted Average Cost	Weighted Average Cost	
70450	Ct head/brain w/o dye	\$ 102	\$ 101	1%
74177	Ct abd & pelv w/contrast	\$ 230	\$ 235	-2%
74176	Ct abd & pelvis w/o contrast	\$ 191	\$ 179	7%
71260	Ct thorax w/dye	\$ 136	\$ 151	-10%
71250	Ct thorax w/o dye	\$ 103	\$ 116	-11%
72148	Mri lumbar spine w/o dye	\$ 258	\$ 277	-7%
70553	Mri brain stem w/o & w/dye	\$ 366	\$ 418	-13%
70551	Mri brain stem w/o dye	\$ 256	\$ 271	-6%
73721	Mri jnt of lwr extre w/o dye	\$ 253	\$ 281	-10%
74183	Mri abdomen w/o & w/dye	\$ 372	\$ 433	-14%

However, it is important to note that it is not just those sites that report data under the square foot method that have data problems. Among providers using the direct or dollar cost allocation methods, over 60% of CT providers and 45% of MR providers had cost estimates that were below 85% of the national average cost.

Therefore, using the CT and MR cost centers in general is fraught with problems.

Do Not Continue with the Planned Policy

The ACR’s concerns are farther reaching than its effects to HOPPS. The use of separate CT and MRI CCRs created unintended consequences on the technical component of CT and MRI codes in the PFS. If this policy is finalized and fully implemented, the resulting reductions in hospital payments would also affect the office practice setting. This is because the HOPPS technical payments would fall below the payment rates in the PFS causing further cuts as mandated by the Deficit Reduction Act of 2005 (DRA). The DRA mandates that the PFS technical payments be paid at the PFS rate or HOPPS rate, whichever is the lower. Based on analysis of CMS data, codes affected by the DRA would experience payment



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reductions up to -52%. We have attached documentation entitled “ACR Comment Letter Appendix” that demonstrates the deterioration of MPFS TC payments by the DRA.

For example, CPT code 93X00 (Dup-scan hemo compl bi std) would experience a -52% decrease in TC payment due to compounding factors of the CT and MR cost center policy and the DRA.

The ACR believes that these linked policies heighten the importance of ensuring that any changes made to the OPFS methodology are fully justified. If payments are insufficient in the outpatient department and payments are lowered under the PFS to the HOPPS rate, access to advance imaging services will become a critical concern in all settings. ***The ACR believes that for the CY 2020 HOPPS final rule, that CMS set weights based on a single diagnostic radiology CCR—the same policy that CMS applied before it created separate CT and MRI standard cost centers in 2011.***

Proposed APC Placement of New and Revised CY 2020 Category I and III CPT Codes

Proposal

CMS included proposed APC placement of new and revised CY 2020 Category I and III CPT codes in Addendum B with a “NI” modifier indicator meaning CMS will accept comments in the proposed rule on the interim APC assignment for the new code.

ACR Perspective and Comments

In March 2019, the ACR presented CMS with recommendations for new CPT codes within APCs for CY 2020. ***ACR is pleased that CMS agreed with a majority of ACR’s recommendations.***

ACR recommended 93X00 (Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study) be placed in Level 3 Imaging without Contrast – APC 5523. However, CMS disagreed with ACR’s proposal and placed 93X00 into Level 2 Imaging without Contrast – APC 5522. ***Based on clinical similarity and resource use, ACR believes 93X00 is more appropriately described by APC 5523 Level 3 Imaging without contrast.***

New Technology Placement for New Nuclear Medicine CPT Codes

Proposal

CMS included proposed APC placement of new and revised CY 2019 Category I and III CPT codes in Addendum B with a “NI” modifier indicator. CMS proposes to placement of several new Nuclear Medicine bundled CPT codes into a standard APC. The table below describes ACR recommendations and the proposed placement by CMS.

HCPCS Code	Short Description	CMS Proposed APC CY 2020	ACR Recommendation	Society Short Version Comment to support recommendations
78X29	PET-CT metabolic, sngl	5593	5594	The added costs of the CT should be recognized by CMS with placement in 5594
78X31	PET-CT, perfusion, sngl	5594	5594	The added costs of the CT can be recognized by CMS with placement in 5594
78X32	PET-CT, perfusion, multi	5594	1522	The ACR supports the new technology application submitted by SNMMI, ACNM and ASNC and supports placement into APC 1522 and 1523 to account for the added costs associated with these services.
78X33	PET, perfusion, single plus PET metabolic single	5594	1523	
78X34	PET-CT, perfusion, single plus PET-CT metabolic single	5594	1523	
+78X35	PET Myocardial Blood Flow quantitation both rest & stress	Add-on		
788X0	Rp Loc SPECT-CT, 1 area	5593		
788X1	Rp Loc SPECT, 2 areas or 2 days	5593		Based on the updated CMS cost data using the deleted codes, and the fact that this is two sets of SPECT, it would make sense to place 788X1 in APC group 5594 to better capture of costs for two day or two sets of SPECT studies.
788X2	Rp Loc SPECT-CT, 2 area or 2 days	5594		We agree with CMS placement.
788X3	Rp quant meas single area	Add-on		

ACR Perspective and Comments

The ACR reviewed the new and revised codes for CPT codes 78X29, 78804 and 788X1 and believe based on the amount of resources as noted above, those codes should be placed in APC group 5594 (Level 4 Nuclear Medicine and Related Services). Based on clinical similarity and resource use, it would not make sense to keep some CPT codes in the same APC group of procedures that are single studies, versus two full sets of studies. Therefore, we urge CMS to move CPT codes 78X29, 78804 and 788X1 into APC group 5594 (Level 4 Nuclear Medicine and Related Services).

Finally, the Society of Nuclear Medicine and Molecular Imaging (SNMMI), American College of Nuclear Medicine (ACNM) and American Society of Nuclear Cardiology (ASNC) jointly submitted a new technology application for CPT codes 78X32, 78X33 and 78X34. As stated in their application, the new



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Category I CPT codes listed above have already been created by the AMA CPT Editorial Panel and will become effective January 1, 2020.

In their joint new technology application, they provide detailed cost information including the most current claims data from the proposed rule. The ACR supports SNMMI, ACNM, and ASNC that these three codes meet the requirements for new technology (e.g. they are not components or items of a more comprehensive service and are expected to be low-volume procedures with a higher probability that payment data will not have a normal distribution) and therefore warrant placement in the CMS new technology APC groups.

Specifically, and per our new technology application, with detailed costs outlines, we recommend CPT 78X32 be placed in APC 1522, CPT 78X33 in APC 1523 and CPT 78X34 in APC 1523. We urge CMS to move those CPT codes into new technology for the CY 2020 final rule.

With respect to CMS' nuclear medicine APC group placements, we strongly urge CMS not to place SPECT CPT code 78803 in APC group 5592; instead, we recommend that CMS place the revised code 78803 in APC group 5593. SPECT CPT code 78803 was revised by the CPT Editorial Panel for 2020, along with the deletion of multiple SPECT codes, including 78320 (SPECT bone), 78607 (SPECT brain), 78647 (SPECT CSF), 78710 (SPECT kidney), 78807 (SPECT infection), 78205 (SPECT liver), and 78206 (SPECT liver and flow). CPT code 78803 is now more generic and will apply to a variety of radiopharmaceuticals and organs going forward. Placement of CPT code 78803 in APC group 5592 would not account for the specialized nature of certain SPECT codes that were deleted during this process; for example, CPT code 78607 (SPECT brain), would not be appropriately reimbursed under APC group 5592, as proposed. We agree with the recommendations of other stakeholders that CMS should consider a weighted average of each CPT code to determine the updated geometric mean, which we believe would place CPT code 78803 squarely in APC group 5593.

Proposed APC Placement of Cardiac CT CPT Codes

Proposal

CMS included proposed APC placement of new and revised CY 2019 Category I and III CPT codes in Addendum B with a "NI" modifier indicator. CMS proposes to place CPT codes 75572 (Ct hrt w/3d image), 75573 (Ct hrt w/3d image congen), and 77574 (Ct angio hrt w/3d image) in APC 5571 (Level 1 Imaging with Contrast).

ACR Perspective and Comments

The ACR believes CPT codes 75572, 75573, and 75574 from APC 5571 to APC 5573, which more appropriately reflects the costs of services that are comparable clinically and with respect to resource use. Cardiac CTA currently is assigned to APC 5571 with other contrast-enhanced studies, such as x-rays and CT scans. However, while cardiac CT may use a CT scanner, it is a different type of exam, and is far more similar to services in APCs 5573 than to services in APC 5571.

Cardiac CTA exams (CPT 75572-75574) are more clinically similar to services in APC 5573, where stress cardiac magnetic resonance imaging, stress echocardiography, and nuclear SPECT MPI testing are placed. Cardiac CTA exams require more time, highly trained technologists, involve higher risk patients, require



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administration of vasoactive medications, and require close monitoring of patients during and after the procedure in direct comparison to other contrast-enhanced imaging studies in 5571.

Proposed Change in APC Placement for CPT Code 0503T

Proposal

CMS proposes to move CPT code 0503T (Coronary Fractional Flow Reserve Computed Tomography) from New Technology APC 1516 (New Technology - Level 16 (\$1,401 - \$1,500)), with a payment rate of \$1,450.50 to New Technology APC 1509 (New Technology - Level 9 (\$701 - \$800)), with a proposed payment rate of \$750.50. CMS proposes that based on the 84 claims.

ACR Perspective and Comments

ACR is concerned about the proposed movement of CPT code 0503T (Fractional Flow Reserve Computed Tomography) from the current New Technology APC 1516 priced at \$1450.50 to APC 1509 at \$750.50, a drastic 50% reduction. FFR-CT is an emerging technology that offers a non-invasive method to derive coronary flow information that is normally obtained from measurements during an invasive angiogram. FFR-CT has been shown to reduce the number of diagnostic coronary angiograms by 61% among patients being assessed for coronary artery disease.

New technologies are disruptive not only from a clinical perspective, but often times from an economic aspect as well. In many instances, new technology may add costs to the system, yet in the case of FFR-CT, it improves patient care while providing cost savings to the system by reducing the need for diagnostic coronary angiography. ACR believes CMS's proposal to move this study to a lower new technology APC without giving it the full 3 years of cost data collection is premature. ***ACR requests that CMS use its authority to maintain the current New Technology APC 1516 placement at the rate of \$1450.00 for FFR-CT for another 18 months and allow the additional time to collect a more meaningful number of claims prior to assigning a new APC and rate.***

Supervision Level for Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals

Proposal

CMS proposes to change the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and critical access hospitals (CAHs). General supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. Currently, direct supervision is required for most hospital outpatient therapeutic services in all hospital providers. However, CMS has not enforced the direct supervision requirement in CAHs and small rural hospitals with fewer than 100 beds for most of the period since March 15, 2010.



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CMS will continue to have the Hospital Outpatient Payment (HOP) Panel provide guidance on the appropriate supervision levels for hospital outpatient services. CMS is seeking public comment on whether specific types of services, such as chemotherapy administration or radiation therapy, should be excepted from this proposal.

ACR Perspective and Comments

The ACR has significant concerns about the proposal to change the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services by all hospitals and CAHs. Ancillary clinical personnel such as nurses and other staff working in the hospital are an essential part of physician-led health care teams. Their education, training, and experience equip them to play an integral role in patient care, but it does not substitute for intensive and specialized training that physicians, including radiologists, radiation oncologists and nuclear medicine physicians receive.

The ACR believes that CMS should require direct supervision for outpatient therapeutic services in the hospital outpatient setting including in CAHs and small rural hospitals with fewer than 100 beds. The ACR believes that CMS should not compromise quality patient care and safety by allowing outpatient therapeutic services to be performed without direct physician supervision. Even in CAHs and small rural hospitals, a physician presence is necessary to ensure safety and quality patient care.. CMS should not implement its proposal to change the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and CAHs.

Conclusion

The ACR appreciates the opportunity to comment on the HOPPS proposed rule. We hope you find these comments provide valuable input for your consideration. If you have any questions, please don't hesitate to contact Christina Berry at cberry@acr.org.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "William T. Thorwarth Jr.", with a stylized flourish at the end.

William T. Thorwarth Jr., MD, FACR
Chief Executive Officer



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CC: Marjorie Baldo, CMS
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