September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1678–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Administrator Verma:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Hospital Outpatient Prospective Payment System (HOPPS) and Quality Reporting Programs.

The ACR provides comment on the following important issues:

1) Proposed Calculation and Use of Cost-to-Charge Ratios
2) Radiology and Imaging Procedures and Services; Imaging APC's
3) APC Placement of CT Lung Code G0297
4) Proposed Treatment of New and Revised CY 2018 Category I and III CPT Codes That Will Be Effective January 1, 2018 for Which We Are Soliciting Public Comments in This CY 2018 OPPS/ASC Proposed Rule
5) Comment Solicitation on Packaging of Items and Services under the OPPS
6) C-APC 5627 (Level 7 Radiation Therapy) Stereotactic Radiosurgery

Proposed Calculation and Use of Cost-to-Charge Ratios

CMS proposes to continue its transitional policy for another year to exclude providers that use the square foot cost allocation methodology to allocate costs for CTs, MRI and cardiac cath. Full implementation would not take place until CY 2019. The ACR appreciates this delay which offers further opportunity to dialog on the challenges radiology departments face under this policy.

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

However, the ACR stands by our recommendation that CMS completely rescind the requirement that hospitals develop CT and MR cost centers and once again allow discretion of the use of cost centers to the hospital.

In the CY 2014 OPPS final rule, CMS implemented a policy for using distinct cost-to-charge ratios (CCRs) for MR and CT procedures separating them from the general diagnostic CCR used for determining reimbursement rates for the rest of the diagnostic imaging studies. This policy removed claims from rate-setting where hospitals utilized the "square foot" method to estimate costs associated with the use of CT and MR. The stated goal of this policy was to allow hospitals to use what CMS considered more accurate cost allocation methods (i.e. dollar or direct) with the goal of improving the accuracy of the totality of the CCRs upon which the OPPS relative payment weights were based. This policy was scheduled to sunset after four years once improved cost report data became available for rate-setting purposes.

CMS' policy to use distinct CCRs for CT and MR is based on a 2009 RTI study that made conclusions about aggregation bias, also known as "charge compression," in hospital CCRs. In the FY 2009 Inpatient Prospective Payment System (IPPS) rule, CMS discussed "a contract [awarded] to 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." (73 FR 48451). Charge compression, occurs when high cost and low-cost services are grouped together in a single cost center. Hospitals tend to mark-up charges for low-cost items more than high cost items. When high cost and low-cost items are grouped together in a single cost center, a single CCR applied to charges will understate the cost of high cost items and overstate the cost of low-cost items.

RTI's study was undertaken shortly after CMS adopted a policy to make the IPPS relative weights based on costs rather than charges. Its purpose was to address charge compression by having more cost uniformity among items grouped together in a single cost center. The principal concern motivating the study was that expensive medical devices were grouped with very inexpensive medical supplies creating underpayment for device dependent APCs and Medicare Severity-Diagnosis Related Groups (MS-DRGs) that include devices. While MR 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 counter-intuitive, it suggests that charge compression with MR and CT cost centers was unfounded. It does not suggest the opposite conclusion—that charge mark-ups are higher in the more expensive MR and CT cost centers than diagnostic radiology.

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

The FY 2018 IPPS rule (82 FR 38103) shows that the CT Scans (0.038) and MR (0.079) CCRs are the lowest among the 19 CCRs used by CMS to determine the IPPS relative weights and significantly lower than the radiology CCR (0.153). These CCRs are suggesting that hospitals are charging more than 26 times their costs for CT scans and nearly 13 times their costs for MR. ACR finds these results to be implausible, particularly considering that the initiation of this issue was to investigate the opposite of what RTI found in its study. It also suggests that how costs are reported to these costs centers are problematic.

Advanced imaging rates have declined since 2007, while other radiology rates have increased to the point where relativities in payment accuracy have been distorted. Figure 1 below demonstrates how the volatility of CT and MR cost center data has deteriorated CT and MR payment rates to the levels of X-ray and ultrasound using the head/brain studies as an example.

FIGURE 1: Head/Brain Imaging Payments Over Time

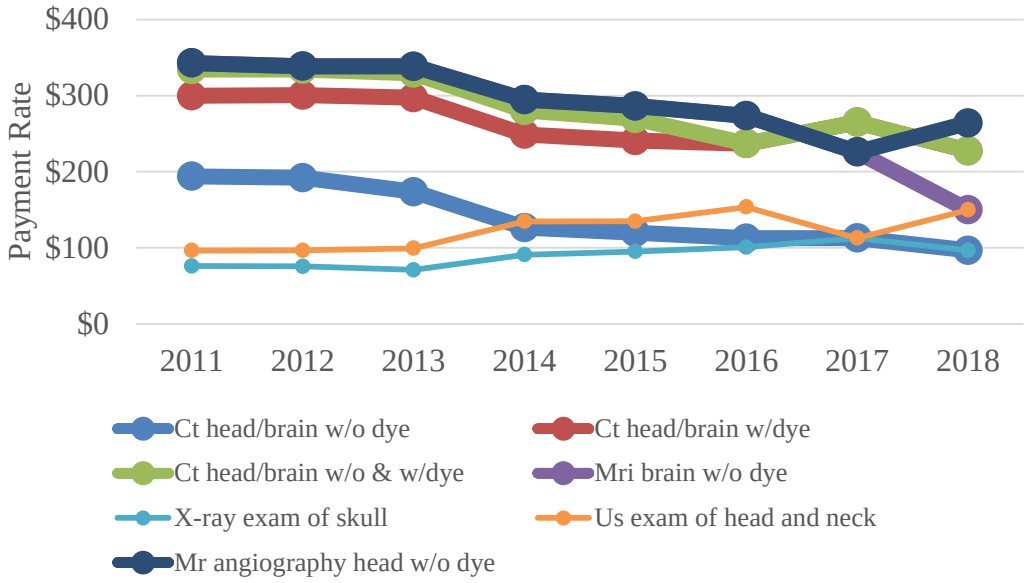


Figure 1 illustrates that a **CT head/brain w/o dye** receives the same payment as **X-ray exam of skull** (in 2017 and 2018) and **US exam of head and neck** (in 2017), and a **MRI brain w/o dye** receives the same payment as **US exam of head and neck** in 2018. These payments represent inaccurate relativities which also exist in other body areas across the imaging APCs. Paying for advanced imaging such as CT and MR at the same rate as X-ray and ultrasound does not make sense when the resources to provide CT or MR are considerably higher, at least three fold, than X-ray and ultrasound. CMS's criterion for payment accuracy rests upon preserving appropriate relativities in cost across procedures.

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

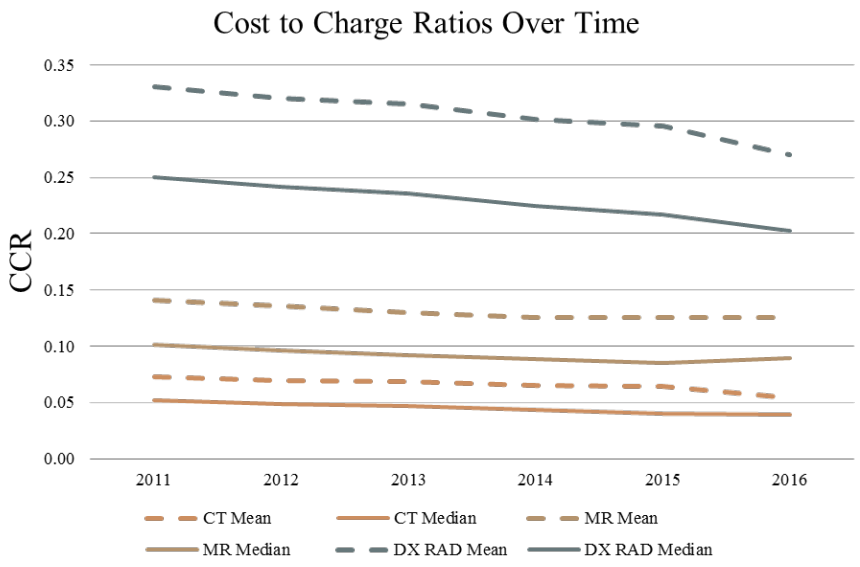
We feel that CMS' recent consolidation of the diagnostic imaging APCs from 17 to 7 and other aggressive packaging policies have contributed to steadily declining payment rates for CT and MR studies. We find evidence in claims data that the effort of hospitals to comply with the CT and MR cost center requirement has largely failed and is contributing to deterioration and distortion in cost data used to set all rates for diagnostic radiology procedures. Table 1 shows, using 2016 data, that only 45% of hospitals have been able to implement CT and MR cost centers using the preferred allocation methods. In their efforts to do so, The Moran Company finds increasing distortion in the CCRs used in all diagnostic imaging rate setting, suggesting that restructuring of cost centers is resulting in costs dropping out of these data, as more and more CCRs approach zero.

TABLE 1. Hospitals have not Successfully Implemented the Required Cost Centers

Total Number of Hospitals Performing Procedures in the Diagnostic Imaging APCs	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 All Hospitals using Non-Square Foot Allocation Method with MR/CT Cost Center
3,499	2,200	63%	1,570	45%

The distortion in CCRs over time is producing declining geometric means for advanced imaging procedures, and large increases in X-ray and ultrasound procedures. Moran Company data in Figure 2 shows that it is declining CCRs, not changes in charging practices, that are driving this decline.

FIGURE 2. Diagnostic Imaging CCRs 2011-2016



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1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

We believe there are several reasons why hospitals have not been successful in making the transition to new cost allocation methods or proper use of the CT and MR cost centers. For example:

- Creating the CT and MR cost centers is a burden on hospitals and their radiology departments because it is difficult to implement their use and allocate costs correctly. Partial efforts result in distorted CCRs, including many that are close to zero. This distortion negatively affects payment accuracy.

- Hospital accounting practices generally need to treat allocations of cost for high cost equipment the same way. Requiring different allocation rules for CT & MR equipment separate from all other high cost equipment in hospitals causes accounting policy problems.

- Pulling costs out of a large complex department like radiology, and pulling capital costs out of overall hospital depreciation and related schedules means re-allocation of cost across all other cost centers. Similar problems may occur in re-allocation of some labor costs such as shared scheduling staff. If accurate re-allocation cannot be achieved, then equipment and other costs are likely left out of the CT & MR cost centers, and Diagnostic Radiology cost centers may also be affected.

Indeed, public comments acknowledged by CMS on this issue in previous final rules suggest the data are 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*.[1]

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 used to set OPPS rates until CY 2018.

[1] FY 2009 IPPS Final Rule, page 48456.

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1891 Preston White Dr
Reston, VA 20191
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Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
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Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

Table 2 also shows the distorted CCR data has caused a decline in the radiology cost-to-charge ratios over the past 6 years.

TABLE 2: CCRs for CT, MR, and Diagnostic Radiology Cost Centers Decline 2011-2016

	Average CCRs		
Year	CT	MR	Diagnostic Radiology
2011	0.0727	0.1407	0.3304
2012	0.0692	0.1353	0.3204
2013	0.0684	0.1299	0.3152
2014	0.0648	0.1256	0.3019
2015	0.0644	0.1256	0.2955
2016	0.0540	0.1256	0.2701
% change from 2011 to 2016	-25.6%	-10.7%	-18.3%

Although the ACR appreciates the delay in fully implementing the CT and MR cost center data until CY2019, we strongly feel that proceeding with implementation of this OPPS policy in future rule making will further depress CT and MR rates resulting in inappropriately low rates and distortion in costs for many advanced imaging procedures. **We strongly believe that the aggregation bias identified years ago was inconsistent with the hypothesis that RTI set out to study has become an incorrect basis upon which to split CT and MR from the diagnostic radiology cost center. The continued use of these separate cost centers is decreasing payment accuracy in the relativities between advanced and standard imaging in OPPS. This inaccuracy also ripples into other payment systems inappropriately affecting radiology payments in other settings.**

The ACR requests that CMS 1) sets diagnostic imaging weights based on a single CCR -- the diagnostic radiology CCR—the same policy that CMS applied before it created separate CT and MR standard cost centers, and 2) discontinue the use of CT and MR cost centers and revert to the previous policy of allowing hospitals to determine their departmental cost center structures according to their accounting policies. It has been a long standing CMS policy that the maximum possible number of claims be used in rate setting. We have verified with CMS staff that the interim policies to select only those claims with preferred cost allocation methods then excludes **all claims** for sites that use the square foot method from rate-setting. This is a large amount of data that is excluded from OPPS calculations. CMS can substitute the diagnostic radiology cost center for all CT and MR reported cost centers and then use all claims in rate setting to produce geometric means that correct for the distortions found in the CT and MR cost centers.

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

Radiology and Imaging Procedures and Services; Imaging APC's

In the 2018 proposed rule, CMS proposes to add a fifth level to the Without Contrast APC family (5525). The rationale offered for creating this new level is:

Specifically, we believe the data support splitting the current [Level 4] into two APCs such that the [Level 4] would include high frequency low cost services and the proposed [Level 5] would include low frequency high cost services.

In addition, we found that CMS did more than simply split procedures from Level 4 into Level 4 and Level 5. Analysis in Table 3 shows that a multitude of codes were moved among the APC levels most likely because of changes to their geometric means when creating the fifth level and making decisions about potential two-times rule violations. We note that CMS does not set forth any criteria on which it bases the splits between levels within an APC family.

TABLE 3: Proposed Rule Code Movement Among the Without Contrast Imaging APCs

APC Level	Number of HCPCS That Remained Unchanged in 2018PR	Number of HCPCS in 2018PR That Were In a Lower-Level in 2017FR
5521	68	-
5522	70	23
5523	34	51
5524	8	33
5525	n/a	31

When the ACR met with CMS in March 2017 seeking an additional level for each of the imaging APC families, our goal was to create some much-needed rate stability within the new APC structure. During that meeting we requested for the CY 2018 without contrast imaging APCs that CMS:

1) Create a 5th Level
2) Minimize the volume within Level 1 to allow more volume at higher levels
3) Lower cutoff for Level 1 to $69 (compared to CMS $75), and
4) Fix all 2-times rule violations.

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

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1818 Market St, Suite 1600
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As demonstrated in Table 4 below, we believe that the payment rates for the imaging codes in the without contrast APCs (5521-5525) would be more stable if CMS were to consider ACR's original proposal of cutoffs for the levels and placement of codes that reside on the border of two levels but the decision of where they sit either stabilizes the payments for the codes in their APC assignments or severely destabilized them as proposed for CY 2018.

TABLE 4: Comparison of CMS' Proposed 2018 APC Structure Versus ACR's Recommendations

APC Level	CMS 2018PR APC Structure				Newly Proposed Structure			
	Geometric Mean	Single Frequency	Min HCPCS Geomean	Max HCPCS Geomean	Geometric Mean	Single Frequency	Min HCPCS Geomean	Max HCPCS Geomean
5521	$62	5,190,177	$21	$75	$61	4,791,656	$21	$69
5522	$100	3,939,499	$76	$125	$105	5,624,662	$70	$138
5523	$156	3,332,261	$120	$229	$180	2,073,520	$142	$251
5524	$275	928,401	$242	$400	$379	1,872,385	$255	$474
5525	$492	1,084,629	$474	$815	$683	112,953	$539	$815

The ACR appreciates CMS' proposal to add an addition of the 5th level to the Without Contrast Imaging APCs. In addition, we request that CMS move the high cost, low volume procedures into Level 5, change the threshold in Level 1 to $69, and fix remaining two times rule violations, and accept the code level recommended placements in the accompanying spreadsheet, to help stabilize payments for radiology services for CY 2018. A spreadsheet with code-level detail will be provided separately to the appropriate CMS staff.

ACR Proposal for Restructuring of With Contrast APCs: Create a Fourth Level

In March, the ACR also requested the creation of a fourth level for the With Contrast APCs (5571-5573). The rationale behind the methodology proposed was to add further payment stability to the codes in these APCs by placing high-cost codes in a new fourth level while adjusting some codes among the levels and addressing any resultant two-times rule violations. Table 5 below shows a comparison of the with contrast imaging APCs as CMS proposes for 2018 versus ACR's recommendations stressing more stability.

TABLE 5: CMS' 2018 Proposed APC Structure Versus ACR's Recommendations

APC Level	CMS 2018PR APC Structure				Newly Proposed Structure			
	Geometric Mean	Single Frequency	Min HCPCS Geomean	Max HCPCS Geomean	Geometric Mean	Single Frequency	Min HCPCS Geomean	Max HCPCS Geomean
5571	$236	482,567	$186	$271	$237	482,563	$186	$271
5572	$353	502,879	$318	$445	$396	800,488	$318	$468
5573	$507	506,416	$454	$993	$539	182,400	$470	$632
5574					$905	26,407	$825	$993

The ACR recommends a 4th level be added to the with contrast imaging APCs in order to add stability and remedy the 2 times rule violations. Our recommendations included placing high-cost codes into a new fourth level, moving some codes from Level 2 to Level 3, fixing resultant 2-times rule violations, and accepting our code level recommendations for placement. A spreadsheet with code-level detail will be provided separately to the appropriate CMS staff.

The ACR requests that CMS provide diagnostic radiology with payment rate stability and be mindful that erratic changes cause instability in other payment systems. CMS does not assert any particular criteria for either the number of levels in large APC families, or any basis for splitting levels. Therefore, we think it appropriate, that at least for diagnostic radiology, CMS adopt a criterion for the structure of these APCs and the cut off points between levels, that chooses to promote rate stability. ACR will be happy to update our recommendations consistent with this policy each year.

Table 6 is an example of all of the cuts that are proposed in the imaging APCs for 2018 that would cause lower payments to the technical component of payments in the office setting in the physician fee schedule (PFS) due to the Deficit Reduction Act of 2005 (DRA).

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

TABLE 6: Studies that take a hit as a result of the 2018 APC restructure and will also have a DRA effect

HCPCS	Descriptor	OPPS 2018PR APC	OPPS 2017FR Payment Rate	OPPS 2018PR Payment Rate	% Change of OPPS Payment Rate (2017FR to 2018PR)
70336	Magnetic image jaw joint	5523	$ 226	$ 150	-34%
70480	Ct orbit/ear/fossa w/o dye	5522	$ 113	$ 97	-15%
70482	Ct orbit/ear/fossa w/o&w/dye	5571	$ 265	$ 227	-14%
70486	Ct maxillofacial w/o dye	5522	$ 113	$ 97	-15%
70490	Ct soft tissue neck w/o dye	5522	$ 113	$ 97	-15%
70544	Mr angiography head w/o dye	5524	$ 226	$ 264	17%
70546	Mr angiograph head w/o&w/dye	5572	$ 427	$ 339	-21%
70547	Mr angiography neck w/o dye	5524	$ 226	$ 264	17%
70549	Mr angiograph neck w/o&w/dye	5572	$ 427	$ 339	-21%
71250	Ct thorax w/o dye	5522	$ 113	$ 97	-15%
71550	Mri chest w/o dye	5524	$ 226	$ 264	17%
73200	Ct upper extremity w/o dye	5522	$ 113	$ 97	-15%
73206	Ct angio upr extrm w/o&w/dye	5571	$ 265	$ 227	-14%

Table 7 shows 30 additional codes that are on the verge of equally as large cuts if the imaging APCs placements and payments are not stabilized moving forward.

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1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

TABLE 7: An Additional 30 Codes are on the Verge of Equally Large Cuts and Further DRA Effects

HCPCS	Descriptor	OPPS 2018PR APC	OPPS 2017FR Payment Rate	OPPS 2018PR Payment Rate	% Change of OPPS Payment Rate (2017FR to 2018PR)
TOTAL					
71552	Mri chest w/o & w/dye	5573	$ 427	$ 488	14%
72191	Ct angiograph pelv w/o&w/dye	5571	$ 265	$ 227	-14%
72192	Ct pelvis w/o dye	5522	$ 113	$ 97	-14%
73202	Ct uppr extremity w/o&w/dye	5571	$ 265	$ 227	-14%
73219	Mri upper extremity w/dye	5572	$ 427	$ 339	-20%
73720	Mri lwr extremity w/o&w/dye	5572	$ 427	$ 339	-20%
74175	Ct angio abdom w/o & w/dye	5571	$ 265	$ 227	-14%
70481	Ct orbit/ear/fossa w/dye	5571	$ 265	$ 227.35	-14%
70496	Ct angiography head	5571	$ 265	$ 227.35	-14%
70498	Ct angiography neck	5571	$ 265	$ 227.35	-14%
71275	Ct angiography chest	5571	$ 265	$ 227.35	-14%
72125	Ct neck spine w/o dye	5523	$ 113	$ 149.67	33%
72127	Ct neck spine w/o & w/dye	5571	$ 265	$ 227.35	-14%
72128	Ct chest spine w/o dye	5523	$ 113	$ 149.67	33%
72130	Ct chest spine w/o & w/dye	5571	$ 265	$ 227.35	-14%

Therefore, the ACR urges CMS to consider all of the payment changes the diagnostic radiology studies have experienced over the past few years with CMS' APC consolidation efforts. In doing so choose to offer some stabilization in payments for not only hospital outpatient departments but also for other settings where these cuts have had rippling negative affects into other payment systems. These outpatient sites regardless of their applicable payment system cannot afford to cover their costs and have stable financial planning with this kind of continued instability.

Low-dose Lung Cancer Screening - APC 5521 (Level 1 Diagnostic Radiology without Contrast)

The ACR is highly disappointed that CMS did not implement our request to place G0297 (LDCT for Lung Cancer Screening) in the same APC as 71250 (CT thorax w/o contrast), APC 5522. As with previous recommendations for new codes, for which cost data has not matured, the ACR suggested that CMS place CT Lung Imaging with 71250 due to its clinical similarity. But, we add that despite the fact that CT Lung (G0297) is a more costly procedure than CT Thorax (71250) as its performance includes steps beyond those required for CT thorax without contract (71250) utilizing structured reporting materials, reporting clinical findings and patient information to data registries.

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

The G0297 APC placement is an additional indication that CMS is moving away from the use of clinical similarity as the basis for constructing the APC families. We further assert that the previously discussed policies related to CT cost centers are contributing to distortion in geometric means for this procedure, and that the integrity of the cost data is suspect when many providers report near negligible costs. A variety of other factors related to a new preventive procedure for high risk patients, have intervened to slow the development of appropriate billing practices for this procedure including reporting requirements, database submissions, and the need for navigators to appropriately track patients. Hospitals will need additional time to update their charge masters and report appropriate cost for this procedure. ***The ACR reiterates its belief that CMS should place code G0297 (CT lung) in APC 5522 along with 71250 due to clinical similarity, regardless of the geometric mean cost data submitted for G0297. This fairly new code and screening benefit has not had time to stabilize nor for hospitals to submit improved data.***

Proposed Treatment of New and Revised CY 2018 Category I and III CPT Codes That Will Be Effective January 1, 2018 for Which We Are Soliciting Public Comments in This CY 2018 OPPS/ASC Proposed Rule

In the 2015 OPPS proposed rule, CMS began the process of assigning new and revised Category I and III CPT Codes to APCs with status indicators for comment in the proposed rule cycle which are then considered final in the final rule and effective January 1 of the calendar year immediately to follow. The new and revised Category I and III CPT Codes are found in OPPS Addendum B and assigned the new comment indicator "NP" to indicate that it is a new or substantially revised code for the next calendar year (CY). In our meeting with CMS in March, the ACR provided recommendations on two of these new codes, 32X99. (Ablat pulm tumor perq crybl) and 382X3 (Diagnostic bone marrow; biopsy(ies) and aspiration(s)). Despite our suggestions, 32X99 was placed in APC 5361 (Level 1 Laparoscopy and Related Services) not the ACR recommended APC 5362 (Level 2 Laparoscopy and Related Services) and 382X3 was placed in APC 5072 (Level 2 Excision, Biopsy, Incision, and Drainage) not ACR recommended APC 5073 (Level 3 2 Excision, Biopsy, Incision, and Drainage). ***The ACR reiterates its recommendations that 32X99 and 382X3 be placed in APCs 5362 and 5073 respectively. It is important for these new codes to be priced correctly before they are subject to APC placement based on their actual cost data.***

Comment Solicitation on Packaging of Items and Services under the OPPS

During CY2016, the ACR submitted technical comments regarding our difficulty determining how payments for codes were calculated at the claim level and in turn, whether all claims are being captured for rate-setting.

Headquarters
1891 Preston White Dr
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Government Relations
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These comments centered on proposed methodological changes to conditionally packaged codes, The ACR expressed the concern that without greater detail either in the body of the rule, or in the claims accounting documents specifying the rules for claim level packaging, we had difficulty replicating CMS' calculations. CMS has been very responsive to questions regarding packaging methodology under the OPPS, however the lack of initial explanation with the release of the rules applies an undue time pressure on the analysis and development of responses by commenters.

As we have stated previously, the OPPS has become increasingly complicated, with many interacting policies and methodologies. Increased transparency can only aid in the development of the OPPS. ***The ACR requests that if CMS is to continue to expand on its packaging policies that CMS should provide an explanation of the methodological changes in the body of the OPPS proposed and final rules.*** CMS has not offered such explanation for the changes in the packaging of services on the same day to packaging of services at the claim level. The ACR is concerned that CMS is losing claims that are then not being used in rate-setting. In the past, ACR has offered help in reviewing methodologies and has found, with the assistance of our consultants, such lost claims and has made recommendations that have been helpful in the development of some of CMS' conditional packaging policies. Therefore, in the spirit of cooperation, the ACR would like to continue to review and help where possible. Especially since a large amount of diagnostic imaging services are subject to CMS' packaging polices.

C-APC 5627 (Level 7 Radiation Therapy) Stereotactic Radiosurgery

Effective in 2016, CMS requires hospital coders to append a –CT modifier to all planning and preparation services related to a stereotactic radiosurgery (SRS) course of treatment for a patient. CMS suggests that in future years CMS will bundle all of these services and pay for all related services in one bundled payment that take place over one month. This could be related to codes on the same claim or on multiple claims. ACR has been working with other radiation oncology stakeholders on this issue and have found thus far that the components of radiation oncology coding are used for many types of radiation therapy patients and patients with cancer often have multiple treatments taking place at the same time for tumors found in one body area and then another, etc. Sometimes multiple techniques are used. Much of this activity appears as inconsistencies in the CMS data per our analysis. Therefore, it is hard to know if a planning, physics or simulation code is being reported for one treatment modality or another. If there are multiples billed in one-month's period of time and CMS makes only one bundled payment, there are services that could have been provided for a different course of treatment that won't be paid for. For example, our research found a significant number of claims that include both SRS and stereotactic breast radiation therapy (SBRT) on the same claim, along with planning and preparation services that cannot be clearly associated with one or other procedure.

Headquarters
1891 Preston White Dr
Reston, VA 20191
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Government Relations
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1818 Market St, Suite 1600
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The costs for the SBRT are then incorporated into the SRS claims because of their C-APC rules and SBRT is not paid for. ***The ACR supports CMS' decision to continue to pay separately for the preparation and planning codes for SRS. We believe this is the best solution in order to keep SRS payments stable in the future.***

Summary of Recommendations

1) **The ACR requests that CMS 1) sets diagnostic imaging weights based on a single CCR -- the diagnostic radiology CCR—the same policy that CMS applied before it created separate CT and MR standard cost centers, and 2) discontinue the use of CT and MR cost centers and revert to the previous policy of allowing hospitals to determine their departmental cost center structures according to their accounting policies.**

2) **The ACR appreciates CMS' proposal to add an addition of the 5th level to the Without Contrast Imaging APCs. In addition, we request that CMS move the high cost, low volume procedures into Level 5, change the threshold in Level 1 to $69, and fix remaining two times rule violations, and accept the code level recommended placements in the accompanying spreadsheet, to help stabilize payments for radiology services for CY 2018.**

3) **The ACR recommends a 4th level be added to the with contrast imaging APCs in order to add stability and remedy the 2 times rule violations. Our recommendations include placing high-cost codes into a new fourth level, moving some codes from Level 2 to Level 3, fixing resultant 2-times rule violations, and accepting our code level recommendations for placement.**

4) **In general, the ACR requests that CMS provide diagnostic radiology with payment rate stability and be mindful that erratic changes cause instability in other payment systems.**

5) **The ACR reiterates its belief that CMS should place G0297 (CT lung) in APC 5522 along with 71250 due to clinical and resource use similarity, regardless of the geometric mean cost data submitted for G0297. This fairly new code and screening benefit has not had time to stabilize nor for hospitals to submit improved data.**

6) **The ACR reiterates its recommendations that 32X99 and 382X3 be placed in APCs 5362 and 5073 respectively. It is important for these new codes to be priced correctly before they are subject to APC placement based on their actual cost data.**

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

7) **The ACR requests that if CMS is to continue to expand on its packaging policies that CMS should provide an explanation of the methodological changes in the body of the OPPS proposed and final rules.**

8) **The ACR supports CMS' decision to continue to pay separately for the preparation and planning codes for SRS.**

Conclusion

Thank you for the opportunity to comment on the proposed rule. We hope you find these comments provide valuable input for your consideration. If you have any questions about our comments please feel free to contact Pam Kassing at 800-227-5463 ext. 4544 or via email at pkassing@acr.org or Dominick Parris at 800-227-5463 ext. 5652 or via email at djparris@acr.org.

Respectfully Submitted,

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

cc: Carol Blackford, CMS
Tiffany Swygert, CMS
Marjorie Baldo, CMS
Elizabeth Daniel, CMS
David Rice, CMS
Erick Chuang, CMS
Twi Jackson, CMS
Norman Thomson, MD, ACR
Zeke Silva, MD, ACR
Pam Kassing, ACR
Dominick Parris, ACR