

September 23, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

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) on the calendar year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Proposed Rule.

In this comment letter, we address the following important issues:

Payment Provisions

- Payment for Evaluation and Management (E/M) Services
- Physician Supervision for Physician Assistants
- Potentially Misvalued Services
- Market-Based Supply and Equipment Pricing Update
- Valuation of Specific Codes

Quality Payment Program

- Merit-based Incentive Payment System (MIPS) Value-based Pathways
- MIPS Value Pathway (MVP) Population Health Quality Measure Set

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- Patient Reported Measures
 - MVP as Permanent MIPS Participation Solution
 - MIPS: Quality Performance Category
 - MIPS: Improvement Activity (IA) Performance Category
 - MIPS: Promoting Interoperability Performance Category
 - MIPS: Cost Performance Category
 - MIPS: Qualified Clinical Data Registry (QCDR)
 - MIPS: Targeted Review
 - Medicare Shared Savings Program (MSSP)
 - Physician Compare

PAYMENT PROVISIONS

Payment for Evaluation and Management (E/M) Services

Proposals

For CY 2021, CMS is building on changes it finalized last year to reduce administrative burden, improve payment rates, and reflect current clinical practice. CMS proposes to adopt the new coding structure for the office/outpatient evaluation and management (E/M) codes as recommended by the American Medical Association (AMA), as well as the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC)-recommended times and values. There will be separate payments for each of the five levels of office/outpatient E/M (instead of the blended payments for levels 2-4), along with a new add-on code for prolonged visits. January 1, 2021 implementation will allow time for feedback, provider education, changes to workflow, and updates to electronic health records (EHRs) and systems.

Office/Outpatient E/M Visit Coding and Documentation

For the E/M services, CMS proposes to adopt the new coding, prefatory language, and interpretive guidance framework issued by AMA/Current Procedural Terminology® (CPT®) to further reduce the burden of documentation. In this framework, history and exam would no longer be the basis for selecting the level for office/outpatient E/M visits. Instead, an office/outpatient E/M visit would include a medically appropriate history and exam, when performed. Therefore, CMS proposes to eliminate the use of history and/or physical exam to select among code levels. CMS proposes to adopt choice of time or medical decision-making (MDM) to determine the level of office/outpatient E/M visit (using the revised CPT interpretive guidelines for medical decision-making).

Office/Outpatient E/M Visit Revaluation (Codes 99202-99215)

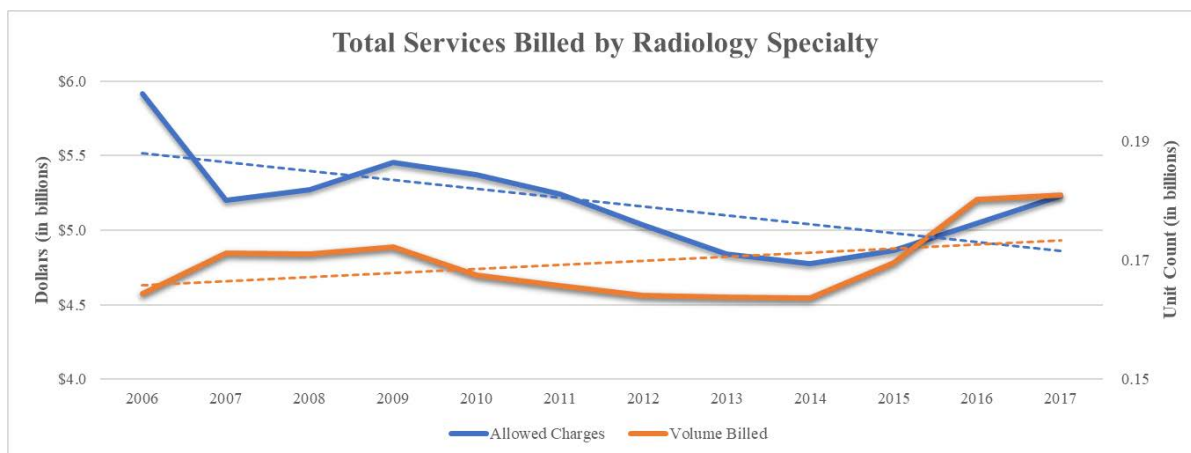
CMS proposes to adopt the RUC-recommended work RVUs for the E/M codes and the new prolonged services add-on code. CMS proposes to establish separate values for Levels 2-4 office/outpatient E/M visits for both new and established patients rather than continue with the

blended rate. CMS proposes to delete Level 1 new patient office/outpatient E/M visit code, 99201. CMS plans to implement changes to the E/M services starting January 1, 2021.

ACR Perspective and Comments

The ACR appreciates CMS’ commitment to reducing physician burden and documentation requirements. We also support the AMA’s purposeful approach to restructuring and revaluing the office-based E/M codes and the concordant increases in primary care payments these updates shall provide. However, the ACR is deeply concerned about the sizable cuts this update will impose upon radiology and other medical specialties who do not frequently bill E/M codes. This will have a devastating impact to the medical community and ultimately negative impact to the patients.

To achieve the main goal above, one of the guiding principles established by the CPT/RUC Workgroup was, **“To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.”** Despite this assertion, the opposite has occurred largely because of the sheer volume with which the office-based codes are billed compared to other specialty services, such as radiology. For instance, the office-based codes receive annual estimated payments of \$23 billion, constituting roughly 25 percent of all MPFS spending.¹ Therefore, within the budget neutral mandates of the MPFS, even a small increase in E/M payment has large effects on specialties that do not bill E/M codes frequently. According to Table 111 in the proposed rule, in the case of radiology, this is an 8 percent reduction. In addition, there is a 6 percent reduction for interventional radiology, 5 percent reduction for nuclear medicine, and 4 percent reduction for radiation oncology and radiation therapy centers. These reductions are on top of approximately 12 percent overall reductions to radiology services from 2006 to 2017 (see graph below).²



Note: 2017 is the most recent year of available Physician Supplier Procedure Summary (PSPS) data. The PSPS is the data source used for this assessment of longitudinal changes in allowed charges for diagnostic radiology services.

¹ The Moran Company Analysis

² The Moran Company Analysis

Analysis conducted by The Moran Company shows that increased valuation of E/M services, without any offset to the conversion factor, would result in increased reimbursement to E/M services of \$5 billion dollars in a single year alone.² Table 1 below shows the estimated single-year budget impact of proposed changes to E/M codes 99202-99215 if implemented in CY 2020.³

Table 1

Existing E&M Codes	Estimated Single Year Budgetary Impact (2020, \$ in billions)
99202	\$0.0
99203	\$0.1
99204	\$0.1
99205	\$0.1
99211	\$0.0
99212	\$0.1
99213	\$1.8
99214	\$2.6
99215	\$0.4
<i>Total New Patient Visits</i>	<i>\$0.2</i>
<i>Total Established Patient Visits</i>	<i>\$4.9</i>
Estimated Impact to Existing E&M Codes	\$5.1

In the proposed rule, it is unclear how CMS is planning to maintain budget neutrality in the MPFS with the substantial increase in the office/outpatient E/M valuations. For medical specialties to best assess the impacts, **the ACR requests that CMS make available the impacts at the CPT code level as soon as possible. In addition, before CMS makes any final decisions, the ACR requests further discussion of impacts and budget neutrality implications in the future rules issued for review and comments.**

In the event that CMS decides to finalize updates to the E/M codes in CY 2021, **the ACR proposes the following remedies.**

- 1) The intent of this effort was not this massive redistribution of MPFS payments. We urge CMS to maintain the same relativity among E/M services and all other services as exists in today's Physician Fee Schedule (PFS). This includes working with the ACR on ways to maintain relativity and payment rates for radiology services.**

³ The Moran Company Analysis

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- 2) **We urge the medical community to work with the Congress to implement positive updates to the conversion factor (CF) to help offset these losses and would value CMS' support in this regard.**
 - 3) **Should these reductions be implemented, we request a dampening policy so that the reductions are phased in over four years. In addition, there should be a ceiling and a floor threshold in terms of percent increase/decrease in payment in a given year.**

Add-on code GPC1X

Proposal

For CY 2021, CMS proposes to revise the code descriptor for GPC1X where it can be billed as applicable with every level of office and outpatient E/M visit. CMS proposes to value this code at 100 percent of the work and time values for CPT code 90785 at work RVU of 0.33. CMS will consider any comments on this code through subsequent rulemaking.

ACR Perspective and Comments

The new code is unnecessary. CMS' intent is to ensure payment for outliers to the typical patients described by the newly revised office visit codes. However, the revised office codes are already designed to capture this complexity. For instance, the descriptor for 99215 is [*Office visit for an established patient with a chronic illness in a severe exacerbation that poses a threat to life or bodily function or an acute illness/injury that poses a threat to life or bodily function*], which clearly describes the highest complexity of the code family. The descriptor for GPC1X [*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*] is poorly defined. We are concerned that the ambiguity of this code and the implicit direction from CMS that it be added to every, or nearly every, office visit creates integrity issues for CMS. For instance, CMS offers no information about how appropriate use will be determined (audited) or what documentation shall be expected. If the intent is to capture services related to care coordination, the MPFS already includes CPT codes for chronic care management (99490 and 99491), transition care management (99495 and 99496), complex condition care management (99487 and 99489) and the proposed "Principal Care Management codes."

We are also concerned with the limited number of specialties projected to receive payment for this add-on code based on comparison of impacts found on Tables 111 and 117 in the proposed rule. Furthermore, the creation of this unnecessary code will needlessly redistribute another \$1.5 billion dollars between specialties at a time when those specialties that do not bill E/M codes face struggles with the massive redistribution triggered by the above-described office based E/M code increases.

The ACR does not support the implementation of GPC1X, a code describing the complexity associated with visits that serve as a focal point for all medical care or for ongoing care related to a patient’s single, serious, or complex chronic condition.

Physician Supervision Requirements for Physician Assistants (PAs)

Proposal

CMS received many comments to its CY 2018 request for information (RFI) regarding supervision requirements for physician assistants (PAs). Under the general supervision requirement, PA services must be provided under a physician’s overall direction. However, the physician does not have to be in the same room or even in the office/suite when the service is being provided. Commenters made the point that PAs are now practicing more autonomously, similar to nurse practitioners and clinical nurse specialists.

Based on comments received, for CY 2020, CMS proposes to revise the regulation that establishes physician supervision requirements for PAs. CMS is proposing to make the revision so that statutory physician supervision requirements for PA services would be met when a PA provides their services in accordance with state law and the state scope of practice rules for the PAs in the state in which the services are provided. Physicians would provide medical direction and appropriate supervision as directed by state law in which the services are performed. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA’s approach to working with physicians in providing their services.

ACR Perspective and Comments

The ACR has significant concerns about this proposal. Physician assistants 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 the intensive and specialized training that physicians, including radiologists, radiation oncologists and nuclear medicine physicians receive. The ACR supports the AMA policy stating that “physician assistants should be authorized to provide patient care services only so long as the physician assistant is functioning under the direction and supervision of a physician or group of physicians.” In addition, as stewards of appropriate imaging, we are concerned with the increased ordering rate of PAs compared to physicians.⁴ Loosening the supervision requirements of PAs may worsen this problem.

⁴ Hughes DR, Jiang M, Duszak R. A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Intern Med.* 2015;175(1):101–107. doi:10.1001/jamainternmed.2014.6349

Including medical school, the vast majority of physician radiologists undergo 10 years of comprehensive training beyond their undergraduate degree. Medical school is followed by a one-year clinical internship, and a four-year residency program interpreting tens of thousands of imaging studies under the supervision of a practicing radiologist. Radiology residency includes extensive training and hundreds of lecture hours in an intensive Radiologic Pathology Correlation Course including comprehensive review of all imaging modalities, the radiologic presentation of a broad range of diseases and pathologic basis from all organ systems, with emphasis on the principles of radiologic-pathologic correlation. Most radiologists elect to continue their training with a one- or two- year post-residency fellowship program in a radiology subspecialty to hone their diagnostic skills in a radiology subspecialty.

By contrast, training to become a PA generally consists of a two- or three-year postgraduate masters or doctoral degree program. PA education and training cannot provide the same foundational learning experience of medical school. The thorough training physicians receive is essential in equipping them to oversee/supervise patient care and in the case of radiologists, selecting the most appropriate radiology examination for the patient, interpreting and performing radiology procedures, accurately diagnosing patients, and minimizing unnecessary tests. Simply put, proper interpretation of imaging exams by highly trained radiologist physicians is critical to the accurate diagnosis and treatment of disease and injury.

In addition to the requisite expertise of radiologists, registered radiologic technologists are similarly critical to the safety and quality of radiology. Under the supervision and in collaboration with radiologists, radiologic technologists operate imaging equipment to acquire images (e.g., they “perform” radiology procedures). The training and certification of registered radiological technologists (many with modality specific certification such as CT and MRI) and Diagnostic Medical Sonographers (also often with subspecialty certification) is highly specialized and extensive. They have expertise in anatomic positioning, equipment protocols, and optimizing image acquisition to maximize image quality while minimizing radiation exposure.

In contrast, PA educational curricula is not tailored to the responsibilities of a radiologic technologist and cannot adequately equip them to perform highly technical procedures like conventional radiography, fluoroscopy, computed tomography, magnetic resonance imaging, nuclear medicine, vascular-interventional or bone densitometry. Utilizing lesser trained PAs to perform imaging exams would endanger Medicare beneficiaries both from the standpoint of radiation safety as well as the likelihood that poorly performed exams could lead to misdiagnosis or patients undergoing costly additional radiology tests and procedures. The safe and appropriate use of imaging is most appropriately conducted utilizing a physician-led team approach where expertly trained radiologists oversee radiological technologists (who are trained in radiation safety and image/acquisition techniques), along with other appropriately qualified clinicians.

In summary, the ACR urges CMS to maintain the current general level of supervision and abandon the proposal to defer to state law and/or medical record documentation of the PA’s approach to working with physicians in providing services to Medicare beneficiaries.

The proposed approach of deferring to state law for oversight will result in significant variability of quality and safety of radiology procedures available among Medicare beneficiaries.

Potentially Misvalued Services

Proposals

CMS is required to periodically identify codes that are potentially misvalued based on certain criteria, such as changes in practice expense, fast growth, codes frequently billed together, or codes that have not been recently reviewed. The RUC may also identify potential codes for review, and publicly nominated codes from individuals or stakeholders are also considered.

CMS received three submissions nominating codes for review. Additionally, CMS also nominated a code for review as potentially misvalued. Two of the nominated codes pertain to radiology. The first publicly nominated code is 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*). The non-imaging code in the family, 10021 (*Fine needle aspiration biopsy, without imaging guidance; first lesion*) was also nominated.

The second code, nominated by CMS, is 76377 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation*). CPT code 76376 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*) is being addressed by CMS for CY 2020. At the time of survey, the specialties argued that the codes are utilized for different patient populations. However, CMS feels that the codes are similar enough that CPT code 76377 should also be reviewed in order to maintain relativity in the code family.

ACR Perspective and Comments

The ACR recently reviewed CPT codes 10021 and 10005 as part of the larger fine needle aspiration (FNA) family during the October 2017 RUC meeting. The codes were valued by the RUC using multi-specialty survey data through a process that included discussion and consideration of intensity. We disagree with CMS' CY 2019 proposed reduction in value for 10021 and 10005, as discussed in our previous comments specific to the valuation of that code family. **The ACR agrees with the commenter that the codes should have a higher value. However, we support the RUC process and urge CMS to accept the previously-recommended RUC values.**

CPT code 76376 was reviewed at the April 2018 RUC meeting after being identified on a screen for Negative Intra-service Work per Unit of Time (IWPUT). CPT code 76377 was not included in the survey because we do not consider the codes to be part of a “family.” Despite the

similarity in the descriptors, these two codes are performed in very different ways for very different clinical indications. The work involved in the two codes differs greatly in its complexity and the resources required. Moreover, 76377 was not identified on any RUC or CMS screen to indicate that it was potentially misvalued. **The ACR understands the desire to maintain relativity in code families. However, we believe these two services are dissimilar enough (performed on different patients, using different equipment, for different clinical indications) that a joint survey is unlikely to achieve the Agency’s goal.**

Market-Based Supply and Equipment Pricing Update

Proposal

For CY 2019, CMS contracted with StrategyGen to review and update the pricing for direct practice expense supply and equipment inputs. This yielded a report with pricing recommendations for approximately 1300 supply and 750 equipment items. While StrategyGen’s findings indicated that the average commercial price for these inputs have remained relatively stable, some medical specialties would experience increases or decreases in their Medicare payments if the changes were adopted. For this reason, a four-year phase in of the new pricing was proposed.

CMS received many comments following its CY 2019 proposed rule, with many concerns about the accuracy of the supply and equipments’ updated pricing. For those items, StrategyGen conducted further research to confirm that the pricing was appropriate. Submitted invoices were also accepted for review and consideration. Following this additional review, approximately 70 supply and equipment items had their prices further updated. Two of those items include the ultrasound room and the vascular ultrasound room, which both yielded a higher price than previously recommended by StrategyGen. The proposed new pricing for the ultrasound room is \$410,303.32, increased from \$369,945.00. The proposed new pricing for the vascular ultrasound room is \$479,753.32, increased from \$466,492.00.

ACR Perspective and Comments

The ACR appreciates CMS’ efforts to ensure accurate pricing for direct practice expense inputs and support the updated valuation of the ultrasound room and vascular ultrasound room.

However, in the Market-Based Supply and Equipment Pricing Update file, the ACR noted an inconsistency with the pricing for the CT room, PET room, and PET-CT room. We believe the price for EL010 (room, PET-CT) is still incorrect. It does not follow logic that EL009 (room, PET) is increasing from \$1,328,996 to \$2,410,677 and EL007 (room, CT) is increasing from \$1,284,000 to \$1,429,967 while a room that is a combination of these two, EL010 (room, PET-CT) is decreasing from \$2,136,283 to \$206,326. This suggests there is a significant error in the contractor’s pricing as nothing has changed in a combined PET-CT room to indicate that a 10-fold decrease in price is warranted, especially when the component prices have both increased.

The ACR is concerned that there remains a significant error in the pricing for EL010 (room, PET-CT) and asks that the Agency investigate this issue further while delaying any price change for this one item.

Proposed Valuation of Specific Codes for CY 2020

Overall Comments

We appreciate CMS explaining their methodologies and rationale for refining or adjusting RUC-recommended values. We agree with CMS in its Proposed Rule that valuation methodologies it used to adjust RUC-valued codes (i.e. survey data, building blocks, increments, magnitude estimation, or crosswalks to key reference services or similar codes) are technically appropriate. However, we remain concerned that CMS has, in some instances, applied these methods in an inappropriate or inconsistent manner. We remain concerned that the mechanisms for these adjustments are not consistently applied and simultaneous, contradictory rationales exist for different codes within this same rule making cycle.

As a specialty society, our most significant point of contention with the methods used by CMS relates to the treatment of time. We agree with CMS that it is “obligated under the statute to consider both time and intensity in establishing work RVUs for PFS services,” as emphasized in different phrasing throughout the Rule. However, many of the methods employed by CMS to arrive at alternative values do not consider intensity in the stated rationale. This is particularly the case when crosswalks are employed for unrelated procedures across different specialties that do not share much in common. Indeed, the Agency employs crosswalks to devalue multiple x-ray codes after explicitly rejecting that valuation methodology in the last rulemaking cycle. Moreover, the Agency consistently uses time values from CMS/Other codes for explicit comparisons or ratio-type adjustments when it has established the precedent that those times are considered invalid for comparison. These choices do not support the view put forward by CMS’ position that both time and intensity are important in determining appropriate relativity.

In this letter, we will identify the code values for which we have concern with the approach taken by CMS, explain our rationale, and when needed, provide what we believe to be a more compelling justification for why the codes warrant a different value.

The ACR welcomes the opportunity to meet with CMS to further discuss the valuation of these codes.

Bone Biopsy Trocar-Needle (CPT codes 20220 and 20225)

CPT code 20225 (*Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)*) was identified as being performed by a different specialty than the one that originally surveyed it. CPT code 20220 (*Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)*) was included as part of the family and both codes were surveyed for CY 2020.

CMS disagrees with the RUC-recommended 1.93 RVU for CPT code 20220, and proposes a crosswalk to CPT code 47000 (*Biopsy of liver, needle; percutaneous*) at 1.65 RVU. CPT code 47000 has the same intra-service time, slightly higher total time, and is one of the key reference codes for CPT code 20220. CMS is uncomfortable with the proposed increase in work RVU for CPT code 20220 from 1.27 to 1.93, given the slight decrease in intra-service time (22 minutes to 20 minutes) and only one minute increase in total time (49 minutes to 50 minutes). CMS feels that the change in work time should be reflected in the work RVU. Additionally, CMS believes that the work involved in CPT code 20220 is similar or less than that of CPT code 47000, justifying the crosswalk to 1.93 RVU.

CMS proposes to crosswalk CPT code 20225 to CPT code 30906 (*Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent*), a work RVU of 2.45, which is lower than the RUC-recommended 3.00 RVU. CPT code 30906 has the same intra-service time and similar total time. CMS noted that the RUC-approved times for CPT code 20225 decreased by about 50 percent, while the RUC-recommended work RVU increased by about 60 percent.

CMS proposes to replace the bone biopsy device (SF055) supply with the bone biopsy needle (SC077) for CPT code 20225. The bone biopsy needle is the current supply input for CPT code 20225 and no rationale was provided to support the change to the bone biopsy device.

The ACR disagrees with CMS' refinement of the RUC-recommended values for CPT codes 20220 and 20225. The specialty reiterates that the liver biopsy code, 47000, which CMS is proposing as a crosswalk for CPT code 20220 is considerably less intense than a bone biopsy, which requires accurate needle placement and has increased risk of damage to adjacent structures (i.e. vasculature, cutaneous and deep nerves, etc.). Similarly, the crosswalk code, 30906, selected for CPT code 20225, is highly inappropriate, as a nosebleed should not be compared to a bone biopsy. Applying CMS' proposed value, the IWP/UT for CPT code 20225 will be lower compared to CPT code 30906. As the AMA letter states, it is not prudent to give much weight to times that are over 30 years old. While the specialty agrees that the RUC-approved times have decreased from the current times, the current IWP/UT for CPT code 20225, is 0.0032, which is nearly zero and indicates a possible anomalous relationship between the current work value and times. Moreover, comparisons to recently surveyed codes, as laid out in the Summary of Recommendation (SOR) and RUC rationale support the recommended RVU for the recently surveyed times. Specifically, procedure codes 62267 (*Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes*) and 32550 (*Insertion of indwelling tunneled pleural catheter with cuff*) both have 30 minutes of intra-service time (like 20225) and similar or greater work RVUs. Therefore, the specialty supports the newly RUC-surveyed and RUC-approved times and values. **The ACR urges CMS to implement the RUC-recommended values of 1.93 for CPT code 20220 and 3.00 for CPT code 20225.**

The ACR does not agree with CMS' decision to substitute the bone biopsy needle (SC077) for the bone biopsy device (SF055). The bone biopsy device is necessary to perform this procedure.

Its omission from the PE inputs in 2004 was an oversight. In the vast majority of cases, deep bone biopsies are performed using a bone biopsy drill device that allows for access to sclerotic bony lesions (e.g. prostate or breast metastasis) in a manner that a bone biopsy needle (Jamshidi) cannot. Failing to accurately include the devices typically used to perform this service in a non-facility setting will likely result in the procedures being pushed to the more expensive facility setting. **The ACR requests that CMS include the bone biopsy device (SF055) in the direct PE inputs for CPT code 20225.**

Pericardiocentesis and Pericardial Drainage (CPT codes 3X000, 3X001, 3X002, and 3X003)

CPT code 33015 (*Tube pericardiostomy*) was identified as potentially misvalued on a screen of codes with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard and CMS/Other codes. The CPT Editorial panel then deleted four codes and created four new codes to describe pericardiocentesis drainage procedures, differentiating by age and to include imaging.

CMS is proposing to refine the values for all four codes in the family. CMS is proposing to crosswalk CPT code 3X000 (*Pericardiocentesis, including imaging guidance, when performed*) to CPT code 43244 (*Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices*) at 4.40 RVU, due to their identical intra-service times and similar total times. CMS also noted that their database search for codes with similar times all had values below the RUC-recommended 5.00 RVU.

CMS is proposing to crosswalk CPT code 3X001 (*Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly*) to CPT code 52234 (*Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)*) at 4.62 RVU, due to their identical intra-service times and similar total times. CMS also noted that their database search for codes with similar times all had values below the RUC-recommended 5.50 RVU.

CMS is proposing 5.00 RVU for CPT code 3X002 (*Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age, or any age with congenital cardiac anomaly*), which is the survey 25th percentile value. The RUC-recommended 6.00 RVU was based on a crosswalk to CPT code 31603 (*Tracheostomy, emergency procedure; transtracheal*), due to their identical intra-service times and similar total times. However, CMS believes that the valuation for CPT code 31603 is an outlier, stating that their database search for codes with similar times only yielded one other code (out of 21) that had a value above 5.00 RVU, with the remaining codes having a value below 4.69 RVU.

CMS is proposing 4.29 RVU for CPT code 3X003 (*Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT Guidance*), which is the survey 25th percentile value. CMS is uncomfortable with the RUC-recommended 5.00 RVU, again due to the increase

in work RVU greatly exceeding the increase in survey times compared to the predecessor codes. CMS performed a database search, which yielded 45 codes with similar times and RVUs below 5.00. CMS also compared CPT code 3X003 to 3X001 and noted that 3X003 should have a lower RVU based on survey responses. CMS feels that CPT code 31254 (*Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)*) supports the 4.29 RVU valuation for CPT code 3X003.

The ACR disagrees with CMS' refinements to the values of the codes in this family. CPT code 3X000 is one of the more intense procedures performed by interventional cardiologists and CMS' proposed value of 4.40 RVU creates rank order issues between this code and other services in the MPFS. CMS' proposed value for CPT code 3X001 of 4.62 RVU does not represent the appropriate increase in intensity relative to CPT code 3X000. While CPT code 3X000 is a planned procedure, CPT code 3X001 is an emergent procedure that includes the work of 3X000 along with suturing an indwelling catheter in place and also managing the catheter. The typical patient for CPT code 3X002 is a child, which increases the intensity of the procedure due to the smaller "target zone" for the needle. CPT code 3X003 requires the same amount of work as CPT code 3X000 and the specialty recommends that they be valued identically. CMS' proposal of 4.29 RVU for CPT code 3X003 will create a rank order anomaly within the family.

All of the refinements to these codes fail to acknowledge the importance of intensity in the valuation process. There should be a distribution of code values at any given intra-service time that reflect varying intensities of the underlying procedures. Clearly, accessing fluid around the heart in a patient with significant illness is one of the more intense procedures, as is emergent tracheostomy. It is illogical for the Agency to insist that all codes of similar times have similar values. **The ACR urges CMS to implement the RUC-recommended values of 5.00 RVU for CPT code 3X000, 5.50 RVU for CPT code 3X001, 6.00 RVU for CPT code 3X002, and 5.00 RVU for CPT code 3X003.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

Intravascular Ultrasound (CPT codes 37252 and 37253)

CPT codes 37252 (*Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)*) and 37253 (*Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)*) were initially addressed by the RUC in January 2015. The codes were brought back to the RUC in October 2018 due to the unexpected increase in utilization. The survey data supported the times and RVUs for CPT code 37252 and 37253 despite the underestimation in utilization.

CMS is proposing to refine the RUC-recommended 1.80 RVU for CPT code 37252 and crosswalk the surveyed code to CPT code 19084 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)*) at 1.55 RVU.

CMS disagrees with the RUC-recommended 1.44 RVU for CPT code 37253 and is proposing 1.19 RVU to maintain the original 0.36 RVU interval between CPT codes 37252 and 37253.

The ACR does not believe that CPT code 37252 requires the same physician work as CPT code 19084. The intra-service time of 20 minutes for CPT code 37252 is very different from that of 19084. Intravascular ultrasound (IVUS) assists in medical decision making during the intervention and is used for problem solving and assessment of adequacy of the intervention by many operators, which could result in further intervention. This inherently is more complex than the 20-minute intra-service time of CPT code 19084, where a breast lesion biopsy and clip placement is performed using imaging guidance. The intra-service time for 19084 is a similar process in every patient and is binary, whereby the lesion is biopsied or not. The findings of IVUS, however, can help determine what the best course of treatment is for the patient.

The RUC-recommended work RVU of 1.80 for CPT code 37252 is supported by the survey key reference service chosen by physicians who perform this service, CPT code 92978 (*Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)*) (work RVU = 1.80 and intra-service time of 25 minutes).

The ACR believes CMS' proposed recommendation for 37253 is not valid because it is based on a calculation and not on survey data, nor is it directly crosswalked to any service. The ACR strongly discourages the use of valuing the increment. This inaccurately treats all components of the physician time as having identical intensity and is incorrect. CMS should carefully consider the clinical information justifying the changes in physician work intensity provided by the RUC.

CMS should rely on valid survey data and relative services in the Physician Payment Schedule such as CPT code 92978 (*Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)*) (work RVU = 1.80 and intra-service time of 25 minutes) and 92979 (*Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)*) (work RVU = 1.44 and 25 minutes intra-service time). The RUC noted that the intensity and complexity to perform these services are similar, warranting a similar work RVU. **The ACR**

urges CMS to implement the RUC-recommended values of 1.80 RVU for CPT code 37252 and 1.44 RVU for CPT code 37253.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

Stab Phlebectomy of Varicose Veins (CPT codes 37765 and 37766)

CPT codes 37765 (*Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions*) and 37766 (*Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions*) were identified on the High Volume Growth screen for services with Medicare utilization over 1,000 that have increased by at least 100 percent from 2004 to 2006. These codes were surveyed in April 2018 and the RUC recommended 4.80 RVU for CPT code 37765 and 6.00 RVU for CPT code 37766. CMS agrees with the RUC recommendations.

The ACR supports CMS' proposal to accept the RUC recommendations for these codes.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

Lumbar Puncture (CPT codes 62270, 622X0, 62272, and 622X1)

CPT codes 62270 (*Spinal puncture, lumbar, diagnostic*) and 622X0 (*Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance*) describe diagnostic lumbar puncture procedures, while CPT codes 62272 (*Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)*) and 622X1 (*Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance*) describe therapeutic lumbar puncture procedures. Both 62270 and 62272 describe procedures without imaging, while 622X0 and 622X1 bundle the lumbar puncture procedure with fluoroscopic or CT imaging guidance.

CMS disagrees with the RUC-recommended values for all four codes. For CPT code 62270, CMS is proposing a crosswalk to CPT code 40490 (*Biopsy of lip*) at 1.22 RVU, citing identical intra-service times and similar total times. CMS is uncomfortable with the RUC-recommended 1.44 RVU, which is an increase over the current RVU, given the decrease in total survey time for the procedure.

CMS is proposing 1.73 RVU for CPT code 622X0, based on the 0.51 RVU difference in the RUC-recommended values for CPT codes 62270 and 622X0.

CMS is proposing 1.58 RVU for CPT code 62272, based on the 0.36 RVU difference in the RUC-recommended values for CPT codes 62270 and 62272.

CMS is proposing 2.03 RVU for CPT code 622X1, based on the 0.81 RVU difference in the RUC-recommended values for CPT codes 62272 and 622X1.

The ACR disagrees with CMS' refinement to the values of the codes in this family. CMS' comparison of a diagnostic lumbar puncture (CPT code 62270) to a lip biopsy (CPT code 40490) is inappropriate and based solely on time comparisons instead of considering the intensity of the work. CMS identifies the lower intra-service time for 62270 compared to its existing intra-service time as a point of concern and to support the reduction in value. However, discussion at the RUC addressed the increase in overall intensity and complexity for this code family due to a change in dominant specialty. Furthermore, the use of the incremental building block to value a service in lieu of available survey data is unjustified. **The ACR urges CMS to implement the RUC-recommended values of 1.44 RVU for CPT code 62270, 1.95 RVU for CPT code 622X0, 1.80 RVU for CPT code 62272, and 2.25 RVU for CPT code 622X1.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam - Sinuses (CPT codes 70210 and 70220)

CPT codes 70210 (*Radiologic examination, sinuses, paranasal, less than 3 views*) and 70220 (*Radiologic examination, sinuses, paranasal, complete, minimum of 3 views*) were identified on a CMS/Other screen for codes with utilization greater than 30,000.

For CPT code 70210, the RUC recommended the 25th percentile 0.20 RVU, which is a slight increase over the existing value of 0.17, citing comparisons to CPT codes 71046 (*Radiologic examination, chest; 2 views*) and 70355 (*Orthopantomogram (eg, panoramic x-ray)*), which have similar times and RVUs. CMS, however, disagrees with the increased valuation and is proposing to maintain the 0.17 RVU, since the total time for 70210 is unchanged and the RUC-recommended 0.20 RVU is at the higher threshold based on their database search of codes with similar times.

CMS agrees with the RUC-recommended 0.22 RVU for CPT code 70220.

The ACR disagrees with CMS' refinement to the value of CPT code 70210 based on the assumption that the value should remain the same since the total time is unchanged. The specialty wishes to reiterate that CPT code 70210 is a CMS/Other code, which means that it was previously valued using an unknown methodology and is therefore unsubstantiated, while the RUC-recommended times and values are survey-based and maintain relativity among the larger family of radiological procedures. **The ACR urges CMS to implement the RUC-recommended 0.20 RVU for CPT code 70210. We appreciate that CMS agrees with the RUC-recommended value of 0.22 RVU for CPT code 70220.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam - Skull (CPT codes 70250 and 70260)

CPT code 70250 (*Radiologic examination, skull, less than 4 views*) was identified on a CMS/Other screen for codes with utilization greater than 30,000. CPT code 70260 (*Radiologic examination, skull; complete, minimum of 4 views*) was surveyed as part of the family.

CMS disagrees with the RUC-recommended 0.20 RVU for CPT code 70250, which is already lower than its existing 0.24 RVU. The RUC approved the lower 0.20 RVU due to a decrease in time for the procedure, and is consistent with the survey 25th percentile value. CMS is recommending 0.18 RVU for CPT code 70250, a crosswalk to CPT code 73501 (*Radiologic examination, hip, unilateral, with pelvis when performed; 1 view*), stating that their database search of codes with the same intra-service time yielded a maximum RVU of 0.18 RVU and that 0.20 RVU would be an outlier value.

CMS disagrees with the RUC-recommended 0.29 RVU for CPT code 70260, which is already lower than its existing 0.34 RVU. The RUC approved the lower 0.29 RVU due to a decrease in time for the procedure, and is consistent with the survey 25th percentile value. CMS is recommending 0.28 RVU for CPT code 70260, by applying the 0.10 increment between the current value for 70250 and 70260 (0.24 RVU and 0.34 RVU, respectively) to the CMS-proposed value for 70250 (0.18 RVU).

The ACR disagrees with CMS' refinement to the values of the codes in this family. Having rejected the previous crosswalk methodology for this code family, it is ironic that CMS is now proposing to value CPT code 70250 with a crosswalk to CPT code 73501. 73510, x-ray of the hip, is much less complex than an x-ray of the skull, so the specialty does not feel this is an appropriate comparison code and that 70250 should be valued higher. The specialty wishes to reiterate that CPT code 70250 is a CMS/Other code, which means that it was previously valued using an unknown methodology and is therefore unsubstantiated, while the RUC-recommended times and values are survey-based and maintain relativity among the larger family of radiological procedures. The ACR does not agree with CMS' use of the incremental building block to value CPT code 70260 in lieu of available survey data. While there was a one-minute reduction in the *pre-service* time, this does not necessarily justify a reduction in physician work. Furthermore, CPT code 70260 is a Harvard-valued code, implying that the time was merely extrapolated and not measured directly. **The ACR urges CMS to implement the RUC-recommended 0.20 RVU for CPT code 70250 and 0.29 RVU for CPT code 70260.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam - Neck (CPT code 70360)

CPT code 70360 (*Radiologic examination; neck, soft tissue*) was identified on a CMS/Other screen for codes with utilization greater than 30,000.

CMS disagrees with the RUC-recommended 0.20 RVU for CPT code 70360, which is an increase over its existing 0.17 RVU. CMS is uncomfortable with the 0.20 RVU, citing the unchanged total time for the procedure and insufficient support for the increase in work RVU. CMS is proposing 0.18 RVU based on a crosswalk to CPT code 73552 (*Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views*), which has similar times.

The ACR disagrees with CMS' refinement to the value for CPT code 70360. The specialty wishes to reiterate that CPT code 70360 is a CMS/Other code, which means that it was previously valued using an unknown methodology and is therefore unsubstantiated, while the RUC-recommended times and value are survey-based and maintain relativity among the larger family of radiological procedures. Having rejected the previous crosswalk methodology for this code, it is ironic that CMS is now proposing to value CPT code 70360 with a crosswalk to CPT code 73552, which actually has an additional minute of intra-service time. CPT code 73552 studies appendicular structures, while CPT code 70360 studies the axial skeleton, which requires the careful review of many more overlapping structures and organs. Axial exams, in general, are more difficult to interpret than appendicular exams and should be valued higher for equivalent views or times. **The ACR urges CMS to implement the RUC-recommended 0.20 RVU for CPT code 70360.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam - Spine (CPT codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120)

CPT codes 72020 (*Radiologic examination spine, single view, specify level*) and 72072 (*Radiologic examination, spine; thoracic, 3 views*) were identified on a CMS/Other screen for codes with utilization greater than 100,000. The family was expanded to include CPT codes 72040 (*Radiologic examination, spine, cervical; 2 or 3 views*), 72050 (*Radiologic examination, spine, cervical; 4 or 5 views*), 72052 (*Radiologic examination, spine cervical; 6 or more views*), 72070 (*Radiologic examination spine; thoracic, 2 views*), 72074 (*Radiologic examination, spine; thoracic, minimum of 4 views*), 72080 (*Radiologic examination, spine; thoracolumbar junction, minimum of 2 views*), 72100 (*Radiologic examination, spine, lumbosacral; 2 or 3 views*), 72110 (*Radiologic examination, spine, lumbosacral; minimum of 4 views*), 72114 (*Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views*), and 72120 (*Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views*).

CMS agrees with the RUC-recommended values for all 12 codes in the x-ray of the spine family. The values are as follows: 0.16 RVU for CPT code 72020, 0.22 RVU for CPT code 72040, 0.27 RVU for CPT code 72050, 0.30 RVU for CPT code 72052, 0.20 RVU for 72070, 0.23 RVU for CPT code 72072, 0.25 RVU for CPT code 72074, 0.21 RVU for CPT code 72080, 0.22 RVU for CPT code 72100, 0.26 RVU for CPT code 72110, 0.30 RVU for CPT code 72114, and 0.22 RVU for CPT code 72120. The values are either identical or very similar to their current values.

The ACR supports CMS' proposal to accept the RUC recommendations for these codes.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

CT-Orbit-Ear-Fossa (CPT codes 70480, 70481, and 70482)

CPT code 70480 (*Computed tomography (CT), orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material*) was identified on a CMS/Other screen for codes with utilization greater than 30,000. The family was expanded to include CPT codes 70481 (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material*) and 70482 (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material followed by contrast material(s) and further sections*).

CMS disagrees with the RUC-recommended (and current) 1.28 RVU for CPT code 70480 and is proposing 1.13 RVU, consistent with the 12 percent decrease in the surveyed procedure time.

CMS disagrees with the RUC-recommended 1.13 RVU for CPT code 70481 and is proposing 1.06 RVU, consistent with the 23 percent decrease in the surveyed procedure time. The 23 percent decrease is applied to the current 1.38 RVU for CPT code 70481.

CMS accepts the RUC-recommended 1.27 RVU for CPT code 70482.

The ACR disagrees with CMS' refinement to the values for CPT codes 70480 and 70481. CPT codes 70480, 70481, and 70482 are CMS/Other codes, which means that they were previously valued using an unknown methodology. The specialty is uncomfortable with CMS' methodology in reducing the work RVU by the percent decrease in physician time given that the previous time and value was unsubstantiated by any known data.

For CPT code 70480, the ACR does not agree with the comparison codes selected by CMS, CPT codes 72128 (*Computed tomography, thoracic spine; without contrast material*) and 71250 (*Computed tomography, thorax; without contrast material*). CPT code 70480 is much more anatomically complex than both codes. CMS compares CPT code 70481 to CPT code 76641 (*Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete*) and CPT code 70460 (*Computed tomography, head or brain; with contrast material(s)*), both of which have lower intra service times and longer total times. However, the intensity and complexity for CPT code 70481 is much higher than both codes due to the imaging modality and anatomy associated with the orbits and the potential to cause permanent damage. The specialty believes that CPT code 70460 is supportive of the 1.13 RUC-recommended RVU for CPT code 70481, as it has similar intra-service time and IWPUT and identical RVU. **The ACR urges CMS to implement the RUC-recommended 1.28 RVU for CPT code 70480 and 1.13 RVU for CPT code 70481. We appreciate that CMS agrees with the RUC-recommended value of 1.27 RVU for CPT code 70482.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

CT Spine (CPT codes 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, and 72133)

CPT code 72132 (*Computed tomography, lumbar spine; with contrast material*) was identified on a CMS/Other screen for codes with utilization greater than 30,000. The family was expanded to include CPT codes 72125 (*Computed tomography, cervical spine; without contrast material*), 72126 (*Computed tomography, cervical spine; with contrast material*), 72127 (*Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections*), 72128 (*Computed tomography, thoracic spine; without contrast material*), 72129 (*Computed tomography, thoracic spine; with contrast material*), 72130 (*Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections*), 72131 (*Computed tomography, lumbar spine; without contrast material*), 72132 (*Computed tomography, lumbar spine; with contrast material*), and 72133 (*Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections*).

CMS agrees with the RUC-recommended values for eight of the nine codes in the family. The values for those eight codes are as follows: 1.22 RVU for CPT code 72126, 1.27 RVU for CPT code 72127, 1.00 RVU for CPT code 72128, 1.22 RVU for CPT code 72129, 1.27 RVU for CPT code 72130, 1.00 RVU for CPT code 72131, 1.22 RVU for CPT code 72132, and 1.27 RVU for CPT code 72133.

CMS did not agree with the RUC-recommended 1.07 RVU for CPT code 72125 and is proposing 1.00 RVU, consistent with the other non-contrast codes in the family. The RUC accepted the specialties' recommendation of 1.07 RVU based on the increased intensity and complexity of the cervical spine but CMS states that this was not reflected in the survey times, which is identical to the other non-contrast procedures.

The ACR disagrees with CMS' refinement to the value for CPT code 72125 simply to match the other "without contrast" codes in the family (CPT codes 72128 and 72131) and without consideration of the intensity and complexity associated with a particular procedure. Codes with the same or similar times can, and should, have varying RVUs to reflect their appropriate intensities. The cervical spine (CPT code 72125) is much more complex since it is more likely to be injured and involves a larger number of articulations requiring assessment. This was addressed in a previous Final Rule, where CMS had proposed identical RVUs for all of the CT spine "without contrast" codes, but ultimately revised the value for CPT code 72125 following additional comment and feedback from the specialties. **The ACR urges CMS to implement the RUC-recommended 1.07 RVU for CPT code 72125. We appreciate that CMS agrees with the RUC-recommended values for the remainder of the code family, CPT codes 72126, 72127, 72128, 72129, 72130, 72131, 72132, and 72133.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam - Pelvis (CPT codes 72170 and 72190)

CPT code 72190 (*Radiologic examination, pelvis; complete, minimum of 3 views*) was identified on a CMS/Other screen for codes with utilization greater than 30,000. The family was expanded to include CPT code 72170 (*Radiologic examination, pelvis; 1 or 2 views*).

CMS proposes to accept the RUC-recommended values for both codes: 0.17 RVU, the existing value, for CPT code 72170 and 0.25 RVU, slightly higher than existing value, for CPT code 72190.

The ACR supports CMS' proposal to accept the RUC recommendations for these codes.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam - Sacrum (CPT codes 72200, 72202, and 72220)

CPT code 72220 (*Radiologic examination, sacrum and coccyx, minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000. The family was expanded to include CPT codes 72200 (*Radiologic examination, sacroiliac joints; less than 3 views*) and 72202 (*Radiologic examination, sacroiliac joints; 3 or more views*).

CMS disagrees with the RUC-recommended values for all three codes, which were all higher than the existing values. For CPT code 72200, CMS is proposing to maintain the current 0.17 RVU instead of the RUC-recommended 0.20 RVU, citing discomfort with the variability in survey times among the specialties and possible ambiguity with the vignette.

CMS is uncomfortable with the increase in value for CPT code 72202, from the current 0.19 RVU to the 0.26 RVU recommended by the RUC, since there is no change in total procedure time. Taking into consideration the incremental difference between the RUC-recommended values for 72200 and 72202 (0.20 RVU and 0.26 RVU, respectively), CMS is proposing a value of 0.23 RVU (0.17 RVU for 72200 + 0.06 increment) for CPT code 72202.

CMS proposes to maintain the current 0.17 RVU for CPT code 72200 instead of the RUC-recommended 0.20 RVU, citing no change in the total time. CMS further states that the RUC-recommended 0.20 RVU would place it toward the higher end of RVUs for codes with identical times.

The ACR disagrees with CMS' refinement to the values of the codes in this family. The specialty wishes to reiterate that CPT codes 72200, 72202, and 72220 are CMS/Other codes, which means that they were previously valued using an unknown methodology, while the RUC-recommended

times and values are survey-based and maintain relativity among the larger family of radiological procedures.

While we agree that there are several x-ray procedures valued at 0.17 RVU with identical times as CPT codes 72200 or 72220, the specialty notes that codes with the same or similar times can, and should, have varying RVUs to reflect their appropriate intensities. The x-ray sacrum family involves the imaging of the axial skeleton, which requires the careful review of many more overlapping structures and organs. Axial exams, in general, are more difficult to interpret than appendicular exams and should be valued higher, even if they have equivalent views or times. The ACR disagrees with the time ratio methodology applied to the RVU refinement for CPT code 72202 instead of relying on available survey data. **The ACR urges CMS to implement the RUC-recommended 0.20 RVU for CPT code 72200, 0.26 RVU for CPT code 72202, and 0.20 RVU for CPT code 72220.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam – Clavicle-Shoulder (CPT codes 73000, 73010, 73020, 73030, and 73050)

CPT code 73030 (*Radiologic examination, shoulder; complete, minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000. The family was expanded to include CPT codes 73000 (*Radiologic examination; clavicle, complete*), 73010 (*Radiologic examination; scapula, complete*), 73020 (*Radiologic examination, shoulder; 1 view*), and 73050 (*Radiologic examination, acromioclavicular joints, bilateral, with or without weighted distraction*).

CMS proposes to accept the RUC-recommended values for all five codes in the family: 0.16 RVU for CPT code 73000, 0.17 RVU for CPT code 73010, 0.15 RVU for CPT code 73020, 0.18 RVU for CPT code 73030, and 0.18 RVU for CPT code 73050.

The ACR supports CMS' proposal to accept the RUC recommendation for these codes.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

CT Lower Extremity (CPT codes 73700, 73701, and 73702)

CPT code 73701 (*Computed tomography, lower extremity; with contrast material(s)*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family was expanded to include 73700 (*Computed tomography, lower extremity; without contrast material*) and 73702 (*Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections*).

CMS proposes to accept the RUC-recommended values for all three codes in the family: 1.00 RVU for CPT code 73700, 1.16 RVU for CPT code 73701, and 1.22 RVU for CPT code 73702.

The ACR supports CMS' proposal to accept the RUC recommendation for these codes.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Elbow-Forearm (CPT codes 73070, 73080, and 73090)

CPT codes 73070 (*Radiologic examination, elbow; 2 views*) and 73090 (*Radiologic examination; forearm, 2 views*) were identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000. The family was expanded to include CPT code 73080 (*Radiologic examination, elbow; complete, minimum of 3 views*).

CMS proposes to accept the RUC-recommended values for all three codes in the family: 0.16 RVU for CPT code 73070, 0.17 RVU for CPT code 73080, and 0.16 RVU for CPT code 73090.

The ACR supports CMS' proposal to accept the RUC recommendation for these codes.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Heel (CPT code 73650)

CPT code 73650 (*Radiologic examination; calcaneous, minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000.

CMS proposes to accept the RUC-recommended value of 0.16 RVU for CPT code 73650.

The ACR supports CMS' proposal to accept the RUC recommendation.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Toe (CPT code 73660)

CPT code 73660 (*Radiologic examination; toe(s), minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000.

CMS proposes to accept the RUC-recommended value of 0.13 RVU for CPT code 73660.

The ACR supports CMS' proposal to accept the RUC recommendation.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

Upper Gastrointestinal Tract Imaging (CPT Codes 74210, 74220, 74230, 74X00, 74240, 74246, and 74X01)

These codes were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family was referred to the CPT Panel, which revised the code set to conform to other families of x-ray codes. The code family includes CPT codes 74210 (*Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study*), 74220 (*Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), 74230 (*Radiologic examination, swallowing function, with cineradiography/ videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study*), 74240 (*Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), 74246 (*Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered*), and two new codes, 74X00 (*Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study*), and 74X01 (*Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; with small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure)*).

CMS proposes to accept the RUC-recommended values for all of the codes in the family: 0.59 RVU for CPT code 74210, 0.60 RVU for CPT code 74220, 0.70 RVU for CPT code 74X00, 0.53 RVU for CPT code 74230, 0.80 RVU for CPT code 74240, 0.90 RVU for CPT code 74246, and 0.70 RVU for CPT code 74X01.

CMS is proposing refinements to the RUC-approved practice expense inputs. CMS is requesting feedback to support the recommended minutes allotted to the “Perform procedure/service –NOT directly related to physician work” for CPT codes 74210, 74220, 74X00, 74230, 74240, and 74246. For CPT code 74230, CMS is also proposing to refine the minutes for “Prepare room, equipment and supplies” and “Prepare, set-up and start IV, initial positioning and monitoring of patient” to the standard 2 minutes, which also impacts the equipment time calculations.

The ACR supports CMS' proposal to accept the RUC recommendations for these codes.

CMS is proposing several refinements to the practice expense inputs. With respect to the work described by “Perform procedure/service –NOT directly related to physician work”, a source of confusion is likely the similarity in CPT descriptor language between these procedures and the much more simple x-rays (radiographs). The procedures discussed in this family are performed

with both spot radiographs (best thought of as traditional x-rays) and live fluoroscopy (i.e. radiography). The technologist is actively working with the patient, preparing barium materials of varying consistencies, repositioning the patient, adjusting settings on equipment, and performing additional technical assessments both in concert with the physician and including work prior to and following the direct assistance of the physician. This demonstrates why the work category is “NOT directly related to physician work”. The PE SOR lays out in more detail the specific steps performed by the technologist, but the key to this family of codes is not confusing the work of these procedures with the more simpler radiographs (i.e. x-rays) of single body parts, which also justifies the increased time for preparation and positioning as discussed below.

For CPT code 74230, the specialty requests two additional minutes (a total of four minutes) for clinical labor activity “Prepare room, equipment and supplies,” because the supplies for this exam exceed a normal radiographic exam. Multiple consistencies of barium must be prepared, including thin liquid, nectar thick liquid, honey-thick liquid, purees, mixed solids, and solids. The varying barium consistencies are delivered by teaspoon, straw, and cup. All of these items must be prepared prior to beginning the exam.

For CPT code 74230, three minutes for “Prepare, set-up and start IV, initial positioning and monitoring of patient” (above the standard two minutes) is necessary because by CMS’ own policy rules these patients need two diagnoses to qualify for the exam, the most common being prior cerebral infarct and pneumonia. The patients are elderly, debilitated, and have multiple comorbidities. They are being positioned upright between a table and fluoroscopy tube with minimal allowance for deviation because the field of view (their oropharynx and larynx) is a small target.

The ACR urges CMS to implement the RUC-recommended three minutes for “Prepare, set-up and start IV, initial positioning and monitoring of patient” and four minutes for “Prepare room, equipment and supplies.”

Lower Gastrointestinal Tract Imaging (CPT Codes 74250, 74251, 74270, and 74280)

These codes were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family includes CPT codes 74250 (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study*), 74251 (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered*), 74270 (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), and 74280 (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered*).

CMS proposes to accept the RUC-recommended values for all of the codes in the family: 0.81 RVU for CPT code 74250, 1.17 for CPT code 74251, 1.04 for CPT code 74270, and 1.26 RVU for CPT code 74280.

CMS is proposing refinements to the RUC-approved practice expense inputs. CMS is requesting feedback to support the recommended minutes allotted to the “Perform procedure/service –NOT directly related to physician work” for each of the codes. CMS is also proposing to refine the equipment time for the room, radiographic-fluoroscopic for CPT code 74250 to conform to the highly technical equipment calculation.

The ACR supports CMS’ proposal to accept the RUC recommendations for these codes.

With respect to the work described by “Perform procedure/service –NOT directly related to physician work”, a source of confusion is likely the similarity in CPT descriptor language between these procedures and the much more simple x-rays (radiographs). The procedures discussed in this family are performed with both spot radiographs (best thought of as traditional x-rays) and live fluoroscopy (i.e. radiography). The technologist is actively working with the patient, preparing barium materials of varying consistencies, repositioning the patient, adjusting settings on equipment, and performing additional technical assessments both in concert with the physician and including work prior to and following the direct assistance of the physician. This demonstrates why the work category is “NOT directly related to physician work”. The PE SOR lays out in more detail the specific steps performed by the technologist, but the key to this family of codes is not confusing the work of these procedures with the more simpler radiographs (i.e. x-rays) of single body parts, which also justifies the increased time for preparation and positioning as discussed below.

The ACR agrees with CMS’ correction to the practice expense related to the calculation of minutes for the radiographic-fluoroscopic room for CPT code 74250.

Urography (CPT Code 74425)

The physician time and work for CPT code 74425 (*Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation*) was combined with services describing genitourinary procedures in 2016. At the time, the RUC decided not to delete the code, and to wait for two years of Medicare claims data before resurveying, so as to distinguish the work of the service separately from the genitourinary procedures.

A change in the patient population yielded increased procedure time, and a higher RUC-recommended value of 0.51 RVU. CMS is proposing to accept the RUC-recommendation.

The ACR supports CMS’ proposal to accept the RUC recommendation.

The ACR appreciates CMS’ acceptance of the direct practice expense inputs as recommended by the RUC.

Abdominal Aortography (CPT Codes 75625 and 75630)

CPT codes 75625 (*Aortography, abdominal, by serialography, radiological supervision and interpretation*) and 75630 (*Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation*) were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000.

CMS proposes to accept the RUC-recommended 2.00 RVU for CPT code 75630.

However, CMS is not comfortable with the RUC-recommended work RVU of 1.75 and is proposing a work RVU of 1.44 for CPT code 75625 based on an analysis to the top key reference service (KRS) 75710 (*Angiography, extremity, unilateral, radiological supervision and interpretation*) (work RVU = 1.75, 40 minutes intra-service time). CMS is proposing a work RVU reduction to 1.44 for CPT code 75625 based on an intra-service time and total-service time ratio with KRS code 75710. The Agency compares the intra-service time ratio between the survey time of 30 minutes and the KRS time of 40 minutes and found a ratio of 25 percent, or a work RVU of 1.31. Additionally, the Agency compares the total-service time ratio between the survey time of 60 minutes and the KRS time of 70 minutes and found a ratio of 14 percent, or a work RVU of 1.51. CMS believes an accurate value for CPT code 75625 would lie between the range of 1.31 and 1.51 RVUs. This is an invalid methodology to identify a RVU range.

In addition, the Agency chooses CPT code 38222 (*Diagnostic bone marrow; biopsy(ies) and aspiration(s)*) (work RVU = 1.44, 30 minutes intra-service time) as a crosswalk to support a proposed work RVU of 1.44 that fits within their range. This is a poor code to use as a crosswalk because 1) it is performed by physicians from a different specialty, 2) it does not involve imaging and exposure to radiation, 3) it does not require intra-arterial access or monitoring of hemodynamic parameters, and 4) it is a much lower risk procedure. The choice of CPT code 38222 for a crosswalk is inappropriate because there is no clinical coherence between both codes. One is a vascular interpretive procedure while the other is a sampling procedure.

The ACR urges CMS to use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing work values for services and not foster flawed methodologies and solely focus on time. The ACR urges CMS to consider the clinical output of 54 physicians who perform this service and the RUC's collective review of the relativity of this service. **The ACR urges CMS to accept a work RVU of 1.75 for CPT code 75625. We appreciate that CMS agrees with the RUC-recommended value of 2.00 RVU for CPT code 75630.**

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

Angiography (CPT Codes 75726 and 75774)

CPT codes 75726 (*Angiography, visceral, selective or superselective (with or without flush aortogram), radiological supervision and interpretation*) and 75774 (*Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)*) were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000.

CMS is proposing to accept the RUC-recommended value for both codes: 2.05 for CPT code 75726 and 1.01 RVU for CPT code 75774.

The ACR supports CMS' proposal to accept the RUC recommendation.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Specimen (CPT Code 76098)

CPT code 76098 (*Radiologic examination, surgical specimen*) was presented at the April 2018 meeting, during which time the specialty expressed concern about the appropriateness of a codes valuation process in which physician time and intensity for a code are reduced to account for overlap with codes that are furnished to a patient on the same day. CMS is requesting feedback on parameters that might be used to indicate when codes that are furnished concurrently by the same provider should be valued to account for overlap in physician work time, intensity, and PE.

CMS is proposing to accept the RUC-recommended 0.31 RVU for CPT code 76098.

The ACR wishes to clarify that CPT code 76098 was reviewed by the RUC in April 2018 as part of the CMS/Other utilization >30,000 screen. At this time, RUC panel members questioned whether 76098 is typically performed with another code on the same patient, same date of service, and by the same provider. Billed together data showed that no single other code was typically performed with 76098, but if multiple codes (in this case all CPT codes representing placement of needle localization device by any imaging modality) were combined, then the billed together threshold was met. The ACR expressed concern about whether or not it is appropriate to combine multiple similar codes when determining billed together status. The ACR noted that adding individual billed together rates will result in double counting when three or more of those codes are billed together, rendering the data inaccurate unless this overlap is accounted for. Additionally, the ACR expressed concern that this method of determining billed together status reflects a change in RUC procedure and should be validated through the Research Subcommittee before establishing precedent. Since this was a complex, multi-code issue, the RUC decided to revisit this issue at the October 2018 RUC meeting where AMA staff could present their research on this matter. In October 2018, the RUC agreed that 76098 is typically performed with one type of needle localization on the same day (any of CPT codes 19281-

19288), and 4 minutes of pre-service time was removed from the survey time to account for overlap in work.

With regard to CMS' request for parameters that might be used to indicate when codes that are furnished concurrently by the same provider should be valued to account for overlap in physician work time, intensity, and PE, the ACR believes this process will be difficult to address in a blanket policy due a lack of rigorous analysis to assess how frequently this unique situation would apply across the RBRVS. Additionally, the existence of any overlapping physician work and the degree of that overlap will depend upon the underlying procedures being compared. The RUC successfully addressed this potential problem for code 76098 by performing the appropriate analyses to ensure accuracy in the assumed time savings. We encourage CMS to avoid blanket policy and to continue to address this issue on a code by code basis when it is clinically apparent that there may be duplicative work.

The ACR supports CMS' proposal to accept the RUC recommendation.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

3D Rendering (CPT Codes 76376)

CPT code 76376 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*) was identified on a screen for codes with a negative intra-service work per unit of time (IWPUT) with 2016 estimated Medicare utilization greater than 10,000 for RUC reviewed codes and over 1,000 for Harvard or CMS/Other codes.

CMS is proposing to accept the RUC-recommended 0.20 RVU for CPT code 76376.

The ACR supports CMS' proposal to accept the RUC recommendation.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

Ultrasound Exam – Chest (CPT Code 76604)

CPT code 76604 (*Ultrasound, chest (includes mediastinum), real time with image documentation*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000.

CMS is proposing to accept the RUC-recommended 0.59 RVU for CPT code 76604.

The ACR supports CMS' proposal to accept the RUC recommendation.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

X-Ray Exam - Bone (CPT Codes 77073, 77074, 77075, 77076, and 77077)

CPT codes 77073 (*Bone length studies (orthoroentgenogram, scanogram)*), 77075 (*Radiologic examination, osseous survey; complete (axial and appendicular skeleton)*), and 77077 (*Joint survey, single view, 2 or more joints*) were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family was expanded to include CPT codes 77074 (*Radiologic examination, osseous survey; limited (eg, for metastases)*) and 77076 (*Radiologic examination, osseous survey, infant*).

CMS is proposing to accept the RUC-recommended values: 0.26 RVU for CPT code 77073, 0.44 RVU for CPT code 77074, 0.55 RVU for CPT code 77075, 0.70 RVU for CPT code 77076, and 0.33 RVU for CPT code 77077.

The ACR supports CMS' proposal to accept the RUC recommendations.

The ACR appreciates CMS' acceptance of the direct practice expense inputs as recommended by the RUC.

SPECT-CT Procedures (CPT Codes 78800, 78801, 78802, 78803, 78804, 788X0, 788X1, 788X2, and 788X3)

The CPT Editorial Panel restructured this family to better differentiate between planar radiopharmaceutical localization procedures and SPECT, SPECT-CT and multiple area or multiple day radiopharmaceutical localization/distribution procedures by revising five codes, creating four new codes, and deleting nine existing codes.

CMS disagrees with the RUC-recommended values for all nine codes in the family. For CPT code 78800 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); planar limited single area (eg, head, neck, chest pelvis), single day of imaging*), the RUC recommended 0.70 RVU. Citing a reduction in physician time, CMS is using a time-to-value ratio calculation to propose 0.64 RVU for CPT code 78800.

CMS disagrees with the RUC-recommended 0.79 RVU for CPT code 78801 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days of imaging or single area imaging over 2 or more days*), which is the current value, citing a reduction in the intra-service time. Instead, CMS is proposing 0.73 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78800.

CMS disagrees with the RUC-recommended 0.86 RVU for CPT code 78802 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); planar, whole body, single day of imaging*), which is the current value, citing a reduction in time. Instead, CMS is proposing 0.80 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78800.

CMS disagrees with the RUC-recommended 1.20 RVU for CPT code 78803 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT), single area (eg, head, neck, chest pelvis), single day of imaging*), which is an increase from the existing value and equal to the survey 25th percentile. Citing a decrease in time, CMS is proposing to maintain the current 1.09 RVU for this code.

CMS disagrees with the RUC-recommended 1.07 RVU for CPT code 78804 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); planar, whole body, requiring 2 or more days of imaging*), which is the current value, citing a reduction in time. Instead, CMS is proposing 1.01 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78800.

CMS disagrees with the RUC-recommended 1.60 RVU for CPT code 788X0 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest or pelvis), single day of imaging*), which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. Instead, CMS is proposing 1.49 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78803.

CMS disagrees with the RUC-recommended 1.93 RVU for CPT code 788X1 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single area of imaging over 2 or more days*), which is the survey 50th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. Instead, CMS is proposing 1.82 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78803.

CMS disagrees with the RUC-recommended 2.23 RVU for CPT code 788X2 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT)*

transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single area of imaging over 2 or more days imaging), which is the survey 50th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. Instead, CMS is proposing 2.12 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78803.

CMS disagrees with the RUC-recommended 0.51 RVU for CPT code 788X3 (*Radiopharmaceutical quantification measurement(s) single area*), which is the survey 25th percentile. To maintain relativity within the code family, CMS is proposing 0.47 RVU for this code based on a calculated 7 percent reduction from the RUC-recommended value.

CMS is proposing refinements to the RUC-approved practice expense inputs. CMS is proposing to refine the minutes for “Prepare, set-up and start IV, initial positioning and monitoring of patient” to the standard 2 minutes for CPT codes 78800, 78801, 78802, 78803, 78804, 788X1, and 788X2, which also impacts the equipment time calculations. For CPT codes 78800, 78801, 78802, 78803, 78804, 788X1, and 788X2, CMS is proposing to refine the equipment times to match the standard calculation for the professional PACS workstation. CMS is also proposing to refine supply item “sanitizing cloth-wipe (surface, instruments, equipment)” to a quantity of 5 for CPT codes 78801, 78804, and 788X2 to conform with the other codes in the family.

The ACR disagrees with CMS’ refinement to the values of the codes in this family. CPT codes 78800, 78801, and 78803, are Harvard-valued codes, implying that their times were merely extrapolated and not measured directly. As the AMA letter states, it is not prudent to give much weight to times that are over 30 years old, especially with available and recent survey data. It is inappropriate to compare current times and values to the surveyed time and value and use that as a basis for adjusting the physician work RVUs. CMS proposes to refine the values for several of the codes based on the RUC-recommended incremental difference between the code and CPT code 78800, which is not an acceptable methodology. **The ACR urges CMS to implement the RUC-recommended values of 0.70 RVU for CPT code 78800, 0.79 RVU for CPT code 78801, 0.86 RVU for CPT code 78802, 1.20 RVU for CPT code 78803, 1.07 RVU for CPT code 78804, 1.60 RVU for 788X0, 1.93 RVU for CPT code 788X1, 2.23 RVU for CPT code 788X2, and 0.51 RVU for CPT code 788X3.**

CMS is proposing refinements to the practice expense inputs. For several of the codes, CMS proposes to refine the clinical labor minutes for “Prepare, set-up and start IV, initial positioning and monitoring of patient” to the standard of two minutes. The ACR disagrees with this refinement, as the RUC has previously accepted a minimum standard of three minutes for this service across all our nuclear medicine codes. The additional minute(s) above the standard PE two minutes is to account for the additional handling of the radiotracer. Handling of a radiotracer requires more supplies, and a heavy leaded syringe holder, not to mention the added care to not contaminate a room, a patient or any equipment. If one drop of a tracer were spilled, it could shut down a room or set into motion a State and Federal set of rules for clean-up. Therefore, CA016

has traditionally been accepted by the RUC for nuclear medicine at a minimum of three minutes as all nuclear medicine services would require administration of at least one radiotracer.

For several of the codes, CMS proposes to reduce the quantity of the *sanitizing cloth wipe (surface, instruments, equipment)* (SM022) from 10 wipes to five wipes. The ACR disagrees with this refinement because if the imaging is typically over 2 day and we need 5 wipes each day, a minimum of 10 wipes is necessary. Also, if we have two radiotracers then we use 10 wipes not 5 wipes because some of the wipes are used on camera and others are used for the place where you receive the radiotracers. Therefore, for nuclear medicine studies that are over two days or have two radiotracers involved we will require 10 wipes. If there is one tracer and only one day of imaging then 5 sanitizing wipes are appropriate.

The ACR urges CMS to implement the RUC-recommended minutes (varies by code) for “Prepare, set-up and start IV, initial positioning and monitoring of patient” and the 10 sanitizing wipes (SM022) for the codes performed over two days or require two radiotracers (varies by code). While the specialty agrees with CMS’ correction to the equipment formulas for several of these codes, we disagree with the refined values or minutes as listed in the proposed rule, as they reflect the refined minutes for “Prepare, set-up and start IV, initial positioning and monitoring of patient.”

Myocardial PET (CPT Codes 78459, 78X29, 78491, 78X31, 78492, 78X32, 78X33, 78X34, and 78X35)

CPT code 78492 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); multiple studies at rest and stress (exercise or pharmacologic)*) was identified on the High Volume Growth Screen with Medicare utilization over 10,000 that increased by at least 100 percent from 2009 through 2014. The CPT Editorial Panel restructured the code family by deleting a category III code, adding six new codes, and revising three existing codes in order to separately identify component services included for myocardial imaging using positron emission tomography.

CMS disagrees with the RUC-recommended value for all nine codes in the family. For CPT code 78491 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); single study, at rest or stress (exercise or pharmacologic)*), the RUC recommended 1.56 RVU. Citing a reduction in physician time, CMS is using a time-to-value ratio calculation to propose 1.00 RVU for CPT code 78491.

CMS disagrees with the RUC-recommended 1.67 RVU for CPT code 78X31 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan*), which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times in this global period. Instead, CMS is proposing 1.11 RVU for

this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 1.61 RVU for CPT code 78459 (*Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed) single study*), which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times in this global period. Instead, CMS is proposing 1.05 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491. Note that Table 20 indicates that CMS is recommending 1.25 RVU for this code.

CMS disagrees with the RUC-recommended 1.76 RVU for CPT code 78X29 (*Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed) single study; with concurrently acquired computed tomography transmission scan*), which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.20 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491. Note that Table 20 indicates that CMS is recommending 1.40 RVU for this code.

CMS disagrees with the RUC-recommended 1.80 RVU for CPT code 78492 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); multiple studies at rest and stress (exercise or pharmacologic)*), due to the decrease in physician time. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.24 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491. Note that Table 20 indicates that CMS is recommending 1.74 RVU for this code.

CMS disagrees with the RUC-recommended 1.90 RVU for CPT code 78X32 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan*), which is based on a crosswalk to CPT code 64617 (*Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed*). CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.34 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491. Note that Table 20 indicates that CMS is recommending 1.84 RVU for this code.

CMS disagrees with the RUC-recommended 2.07 RVU for CPT code 78X33 (*Myocardial imaging, positron emission tomography, combined perfusion with metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed), dual radiotracer (eg, myocardial viability)*). CMS believes this will result in overvaluing this

procedure compared to other codes with similar times. CMS is proposing 1.51 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491. Note that Table 20 indicates that CMS is recommending 1.71 RVU for this code.

CMS disagrees with the RUC-recommended 2.26 RVU for CPT code 78X34 (*Myocardial imaging, positron emission tomography, combined perfusion with metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan*), which is based on a crosswalk to CPT code 71552 (*Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences*). CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.70 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491. Note that Table 20 indicates that CMS is recommending 1.90 RVU for this code.

CMS disagrees with the RUC-recommended 0.63 RVU for CPT code 78X35 (*Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography, rest and pharmacologic stress (List separately in addition to code for primary procedure)*), which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other ZZZ global period codes. Citing a 1/3 reduction in value for CPT code 78491, the code that CMS uses as the base for their valuations of other codes in this family, CMS is proposing 0.42 RVU for this code based on a calculated 1/3 percent reduction from the RUC-recommended value of 0.63 RVU. Note that Table 20 indicates that CMS is recommending 0.64 RVU for this code.

CMS is proposing refinements to the RUC-approved practice expense inputs. CMS is proposing to refine the equipment times to established policies for non-highly, as well as highly technical equipment. CMS is proposing to refine the equipment times to match the standard calculation for the professional PACS workstation. CMS is proposing to assume a 90 percent equipment utilization rate for the new equipment items “PET Refurbished Imaging Cardiac Configuration” and “PET/CT Imaging Camera Cardiac Configuration.” CMS is also proposing to refine supply item “sanitizing cloth-wipe (surface, instruments, equipment)” to a quantity of 5 for CPT codes 78X33 and 78X34 to conform with the other codes in the family. CMS proposes not to price new equipment item “Software and hardware package for Absolute Quantitation” since the submitted invoices include a service contract and a software bundle without a clear breakdown of the pricing.

The ACR disagrees with CMS’ refinement to the values of the codes in this family. However, given that Table 20 displays different values than the text in the proposed rule, it is difficult to comment on the proposed values for this code family. We are concerned about the rank order issues associated with the proposed values for these myocardial PET codes and their relativity to codes such as SPECT with or without CT and planar imaging procedures. The work of higher levels of PET should not be valued similarly to planar work.

The ACR does not agree with CMS' application or use of incremental differences to values procedures codes, which is not an acceptable methodology, instead of available survey data. CMS proposes the application of a time ratio to value CPT code 78491, and reduced the proposed value of CPT code 78X35 by 1/3 based on the 1/3 reduction in (proposed) value for CPT code 78491. **The ACR urges CMS to implement the RUC-recommended values of 1.61 RVU for CPT code 78459, 1.76 RVU for CPT code 78X29, 1.56 RVU for CPT code 78491, 1.67 RVU for CPT code 78X31, 1.80 RVU for CPT code 78492, 1.90 RVU for 78X32, 2.07 RVU for CPT code 78X33, 2.26 RVU for CPT code 78X34, and 0.63 RVU for CPT code 78X35.**

CMS is proposing refinements to the practice expense inputs. For several of the codes, CMS proposes to reduce the quantity of the *sanitizing cloth wipe (surface, instruments, equipment)* (SM022) from 10 wipes to five wipes. The ACR disagrees with this refinement because if the imaging is typically over 2 day and we need 5 wipes each day, a minimum of 10 wipes is necessary. Also, if we have two radiotracers then we use 10 wipes not 5 wipes because some of the wipes are used on camera and others are used for the place where you receive the radiotracers. Therefore, for nuclear medicine studies that are over two days or have two radiotracers involved we will require 10 wipes. If there is one tracer and only one day of imaging then 5 sanitizing wipes are appropriate. **The ACR urges CMS to implement the RUC-recommended 10 sanitizing wipes (SM022) for CPT codes 78X33 and 78X34.**

The specialty submitted four invoices with our RUC submissions related to the "Software and hardware package for Absolute Quantitation" equipment item. **We urge CMS to reconsider these invoices, as well as any additional information or invoices submitted through the comment period. The ACR will continue to seek additional invoices.**

The specialty agrees with CMS' correction to the equipment formulas for this code family.

The ACR disagrees with CMS' proposal to apply a 90 percent utilization rate for both PET and PET/CT equipment. CMS has not based this decision on any data and did not ask the societies if any information was available. As a point of information, the FDA does require the manufacturers of Rubidium generators to track aspects of the delivery of this radiotracer. One of the data points collected each day from each facility is the number of patients imaged with Rb 82 from each of their generators. (NOTE: The great majority of facilities use just one generator at a time.) These data, which have been collected for over seven (7) years, show an overall average of 4.5 patients imaged per facility per day. CMS should receive more specific information from manufacturers and providers however the RUC can share our medical specialty expertise in that Hospitals can perform Cardiac PET or PET-CT and Oncology PET or PET-CT procedures with the same or similar resources (shared PET or PET-CT equipment and personnel). However, that is not the case in the physician office. The PET and PET-CT scanners and personnel in cardiology practices are typically, more than 50 percent of the time, dedicated for Cardiac PET only. Our experts that perform Cardiac PET and PET-CT in the physician office and IDTF setting confirm that a 50 percent utilization would be a more accurate utilization that is based on

data and not CMS inaccurate assumption. **The ACR urges CMS to use the 50 percent utilization rate on both the PET and PET-CT equipment.**

QUALITY PAYMENT PROGRAM (QPP)

Merit-based Incentive Payment System (MIPS) Value-based Pathways

MIPS Value-based Pathways - Framework

Proposal

CMS proposes to apply a new Merit-based Incentive Payment System (MIPS) Value Pathways (MVP) framework to future proposals beginning with the 2021 MIPS performance period/2023 MIPS payment year to simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. Although CMS would aim to implement the MVP framework as early as feasible, CMS proposes to apply the framework beginning with the 2021 performance period so that it can seek feedback on the details of this framework and address additional details of the methodology in next year's rulemaking cycle. CMS intends to continue to integrate new MVPs so that eventually, all MIPS eligible clinicians would have to participate through an MVP or a MIPS alternative payment model (APM). CMS also plans to engage with clinician professional organizations and front-line clinicians to develop the MVPs.

ACR Perspectives and Comments

The ACR appreciates CMS' recognition of the need and intention to simplify the MIPS program with the aims of improving value, reducing burden and enhancing patient experience and choice. **The ACR agrees that an improved MIPS program should be a more cohesive participation experience for clinicians, provide actionable data and feedback to participants and encourage the patient voice.**

As with any program of this size, the details of implementation are key. While modifications and improvements to the MVP framework would be expected over time, to begin the program prematurely before key pillars are constructed would only serve to add to the existing confusion surrounding participation in MIPS. CMS states that it proposes to "apply" the framework beginning in 2021. **The ACR seeks clarification on exactly what "applying the framework" means or entails.** The ACR believes that 2021 would be too soon to finalize anything more than the major components and starting points of the MVP program, and specifically too early to implement even a "pilot" MVP. Areas to be addressed within the framework would include components such as the required elements of an MVP, number per specialty allowed, approval process, assignment approach, integration of population health measures, benchmarking and equitable comparisons across specialties, new approaches to development of cost and promoting interoperability measures.

MVP Guiding Principles

Proposal

CMS requests public comments on the MVP guiding principles, as well as on how to best develop MVPs to allow for the development of better comparative data, reduce burden, and provide valuable information to patients and clinicians.

ACR Perspectives and Comments

The ACR sees the idea of the MIPS Value Pathways theoretically as a move in the right direction, if use of MVPs can truly reduce burden and make participation in Quality Payment Programs (QPPs) more relevant and useful to both patients and clinicians. We encourage CMS to continue brainstorming for a more holistic approach to the MIPS category requirements and participation that focuses on whether a condition, service or episode of care is delivered efficiently, effectively, timely and in a patient-centered manner and distancing the focus on a certain number of measures being reported and scored.

We also recognize that the MVP concepts and framework must incorporate some flexibility to account for variation in specialties' size, practice arrangements and uniqueness in care delivery that may make variant MVPs a necessity. For example, as in the current state of MIPS, there are modified requirements for "special status" clinicians such as non-patient facing or specialty type that adjust or reweight these clinicians' level of participation in the Cost, Improvement Activities (IA) and Promoting Interoperability (PI) categories. Considering these restrictions, if for MVPs CMS is statutorily able and open to developing and using innovative Cost (i.e. facility based imaging utilization metrics or adherence to imaging clinical decision support) or PI measures (not solely associated with certified EHR technology (CEHRT) but other health IT systems) then that may open the door for more meaningful participation in those categories for specialties like radiology.

Over the coming months, the ACR looks forward to an ongoing dialogue with CMS on the MVP framework and additional opportunities to provide input and suggestions beyond this RFI comment period.

MVP Assignment

Proposal

CMS seeks feedback on the level of choice that should be provided to clinicians for MVP selection or selection of measures and activities within an MVP. Should clinicians and groups be able to self-select an MVP or should an MVP be assigned?

If assigned, CMS requests comments on the best way to assign an MVP – should it be based on place of service codes, specialty designation on Part B claims, or in the case of groups, should

the assigned MVP(s) be based on the specialty designation of the majority of clinicians in the group, specific services, or other factors?

ACR Perspectives and Comments

At this point in the creation of the MVP framework and MVP examples, **the ACR recommends that clinicians and groups should be able to self-select or opt-in to a specific MVP rather than being assigned to one by CMS based on default by specialty designation or previous MIPS participation.** While assignment would alleviate the burden of decision-making and choice on the part of the clinician, it also requires proactive awareness on the part of a clinician or group that there is a need to confirm the MVP to which they are assigned. Additionally, creating a universally fair and applicable method for automatic MVP assignment across specialties or clinician types would be challenging, similar to the attribution rules, which resulted in patients being attributed to radiologists under the Total per Capita Cost measure during field testing last year.

Selection of Measures and Activities for MVPs

Proposal

CMS also seeks comment on circumstances when it should allow clinicians and groups to select an alternative MVP, rather than the one or more MVP(s) assigned. For quality measures, CMS seeks comment on whether it should initiate a “**Call for MVPs**” that aligns with policies developed for the Call for Measures and Measure Selection Processor or if CMS should use an approach similar to the process used to solicit recommendations for new specialty measure sets and revisions to existing specialty measure sets.

ACR Perspectives and Comments

A call for MVPs may be the most reasonable process by which to propose a pathway since CMS currently has mechanisms in place to support that approach. However, **the ACR has concerns and would caution CMS to thoughtfully consider and identify staff resources with which to ensure that the selection process is not prone to issues that have existed with the annual QCDR self-nomination process.** For instance, the methodology that CMS has used to determine which QCDR measures are accepted for the following reporting year has not been transparent, although the ACR recognizes that CMS is working to improve QCDR approval processes. The MVP and the QCDR measure selection process should be unambiguous and the standards for measure selection should be publicly available.

Proposal

CMS seeks feedback on what **criteria should be used for determining which measures and activities should be included in an MVP**, such as prioritizing outcome, high priority and patient-reported measures; **limiting the number of quality measures to four**; including only

cost measures that align with quality measures; etc.? How should performance categories and associated measures and activities be linked (e.g., quality measures aligned with cost measures)?

ACR Perspectives and Comments

Again, the ACR views part of the attractiveness of the MVP concept as a move away from the debatable arbitrary identification of a specific number of required quality measures. Yet we understand the need to be equitable in requirements across MVPs and it would be problematic to vary that number. The suggestion of four measures seems reasonable but would need to be analyzed further as the framework is solidified.

Proposal

CMS seeks input on how many improvement activities should be included in an MVP, how much flexibility should there be in selecting improvement activities, and to what extent should improvement activities in MVPs be specialty-specific or condition-focused versus focused on other areas relevant to the practice, such as patient experience and engagement, team-based care, and care coordination. For instance, should attestation to participation in a specialty accreditation program satisfy the improvement activities performance category requirements for an MVP? CMS is interested in exploring approaches to leverage participation in specialty accreditation programs, such as the American College of Surgeons' Commission on Cancer accreditation program, since these programs may promote the evaluation and improvement of clinical processes and care. Should this option be available for all MVPs or limited to specific MVPs, such as particular specialties for which accreditation programs are available? What criteria should we use to identify such programs?

ACR Perspectives and Comments

The ACR believes that the selection of improvement activities (IA) for an MVP should allow for use of any IA in the approved CMS list. However, the MVP "steward" should identify and describe how the selected IA's integrate or are related to the focus of the MVP. Additionally, a number of current IA's are cross-cutting and could be met through various specialty-relevant activities. For example, IA_PSPA_7, "Use of QCDR data for ongoing practice assessment and improvements," could be relevant to a myriad of specialty or condition-focused MVPs.

We support CMS' idea to allow attestation of participation in a specialty accreditation program to satisfy the IA requirement for an MVP. Currently, radiology practices can meet IA_PSPA_18 "Measurement and Improvement at the Practice and Panel Level" by achieving status as a Diagnostic Imaging Center of Excellence (DICOE) through the ACR (<https://www.acraccreditation.org/Diagnostic-Imaging-Center-of-Excellence>).

MVP Implementation

Proposal

CMS is interested in feedback on approaches to accelerate the development and implementation of MVPs, as well as any comments on the optimal timeline for transition. CMS intends to transition to MVPs beginning with the 2021 MIPS performance period/2023 MIPS payment year. What practice level operational considerations does it need to account for in the timeline for implementing MVPs?

ACR Perspectives and Comments

MVP development will primarily be shouldered by specialty societies. **CMS should consider the impact that this will have on societies as they currently maintain activities and processes to support their members' success in the MIPS program, including measure development and QCDR operations and maintenance.** These are not small efforts. Member and staff volunteers who support these activities will potentially be pulled away to focus on MVP needs. Some societies may have more available resources than others, which could create inequities in MIPS program options across specialties.

MVP Collection of Quality Measures

Proposal

CMS is requesting feedback on whether clinicians and groups should be required to use a certain collection type for quality measures (eCQMs, MIPS Clinical Quality Measures [MIPS CQMs], CMS Web Interface, or QCDR measures) in order to have a comparable data set in the MVPs. CMS would also like to know what clinicians' administrative burden would be for changing to a new, specific collection type for a measure, for example, changing from MIPS CQM to an eCQM.

ACR Perspectives and Comments

The ACR does not recommend limiting quality measures in an MVP to those of a certain collection type. Relevant measures to an MVP may cross over collection types. Could a group or eligible clinician's performance on an individual measure in an MVP be compared against the benchmarks for that collection type as it is done now in MIPS? Additionally, we have some concerns about limiting MVP measures to certain collection types as small or rural practices may be able to participate in an MVP through continued use of claims measures. Allowing multiple MVP measures to be submitted via multiple collection types would be consistent with CMS policy allowing clinicians to report MIPS measures via multiple collection types.

MVPs and Small Practices

Proposal

CMS requests the following comments on policies to support small practices:

- How should CMS structure the MVPs to provide flexibility for small and rural practices and reduce participation burden? What MVP-related policies could best assist small and/or rural groups when submitting measures and activities? Should CMS have alternate measures and activities submission requirements for small and/or rural practices? For example, should small and/or rural practices be allowed to report fewer measures and activities within an MVP?
- How can CMS mitigate challenges small and/or rural practices have in reporting? What types of technical assistance would be most helpful to help small and/or rural practices to have successful participation in MVPs?
- How can CMS reduce barriers to small and/or rural groups transitioning into APMs, such as lack of information on performance on quality and cost measures and limited resources?
- What approaches could help small practices transition to MVPs?

ACR Perspectives and Comments

We strongly recommend that CMS maintain all current policies that assist small and rural groups.

MVPs and QCDRs

Proposal

CMS requests comments on policies for how QCDR measures would be used in MVPs. Should QCDR measures be integrated into MVPs along with MIPS measures, or should they be limited to specific MVPs consisting of only QCDR measures? How does CMS continue to encourage clinicians to use QCDRs under MVPs?

ACR Perspectives and Comments

The ACR believes that QCDR measures should be integrated into MVPs, not limited to specific MVPs consisting of only QCDR measures. If QCDR measures are limited to QCDR-only MVPs, this could limit the number of clinicians who report these measures. This has the potential for unintended consequences; low-reported measures could seem invaluable. Many QCDRs also report MIPS CQMs, so a combination of those measure types could be submitted using a QCDR. Also, QCDR measures are, by definition, the most specialty-specific and should be the most well-suited measures for an episode-based, practice specific integrated assessment proposed for MVPs.

MVP Population Health Quality Measure Set

Proposal

CMS plans to increase the use of global and population based administrative claims-based quality measures and outlines a proposal to add at least one additional administrative claims-based quality measure starting in the 2021 MIPS performance period. CMS requests comments on the topics related to the use of a population health quality measure set, such as the following: what specific administrative claims-based quality measures CMS should consider; should administrative claims-based quality measures be used to replace some of the reporting requirements in the quality performance category; what other information or methods should be used to mitigate concerns about administrative claims-based quality measure reliability, applicability, and degree of actionable feedback for clinician performance improvement?

ACR Perspectives and Comments

The ACR has concerns about the feasibility of implementing administrative claims-based quality measures that would be attributable to all clinicians and groups in the MVP program. This is currently an issue with the existing MIPS administrative claims quality and cost measures that are largely not applicable to radiologists. How would this play out in the MVP framework? For MVPs where there are no attributable measures, would the category scoring be adjusted to allow for this and provide an equitable scoring solution for such clinicians? The ACR also has questions about the level of transparency of the measure attribution and calculation that would be available, as well as enough detailed feedback on measure performance to allow improvement.

Patient Reported Measures

Proposal

CMS has requested public comments on enhancing the patient voice in the MVPs. Specifically, CMS requests information regarding when patient experience/satisfaction measurement tools or approaches to capturing information would be appropriate for inclusion in MVPs. Additionally, how could current commercial approaches for measuring the customer experience outside of the healthcare sector (for example, single measures of satisfaction or experience) be developed and incorporated into MVPs to capture patient experience and satisfaction information?

ACR Perspectives and Comments

Many of these patient experience/satisfaction measures have already been deployed in the ACR's custom surveys to assess the experiences of patients regarding imaging procedures. **There should be pathways for surveys that fit proposed criteria to be approved for inclusion in MVPs beyond Consumer Assessment of Healthcare Provider and Systems (CAHPS).**

Development of CAHPS surveys are time-consuming and costly and may limit certain specialties from participating in patient experience/satisfaction measurements.

Patient feedback regarding experiences with care providers, with care experiences, or with disease/issue management is key to the management of outcomes and population health. Many stakeholders have and continue to solicit patient/customer/consumer feedback in order to provide meaningful paths to ensuring that a product, service, or experience meets or exceeds expectations and of which the patient/customer/consumer has a positive evaluation. Stakeholders include healthcare providers (hospitals, offices, physician groups) product/service providers (such as companies that provide equipment, medical devices, pharmaceuticals, health insurance providers, etc.) as well as regulators/legislators (CMS, etc.).

The following recommendations utilize types of questions commonly deployed in industry to assess customer/consumer/patient evaluation.

For patient feedback to provide meaningful direction to the sponsor(s), it must be accurate and reliable. This means that the data gathered must be representative of the population and the methodology must yield predictable data. Feedback can be retrospective, comprised of patients recalling an experience (with a hospital, physician, procedure, etc.); it may also be longitudinal, with patients providing expectations of an experience (the Pre-wave), and patients then providing their evaluation following the experience (the Post-wave). Feedback may also be prospective only, obtaining expectations and attitudes specific to an experience.

The ACR also suggests the following considerations regarding the sample. Defining the sample begins with defining the population one wishes to understand. For example, that definition can be as focused as patients who undergo a certain procedure at a certain place of service or it can be as general as average risk women who are aged 40 and older (e.g., identified as eligible for mammography screening).

If the goal is to quantify an experience among a sample of patients, one must ensure that the sample interviewed as part of a survey reflect the demographic/socio-economic characteristics of that population. Otherwise, the results may not be reflective of the population. Because of this, it may be difficult to provide information at the clinician level that would be meaningful for patients. The number in a sample, as a proportion of the population, will introduce an error range around the statistics produced, so it is necessary to ensure that any sample is a statistically stable base. Also, who responds/answers the survey may introduce bias, so it is imperative that the data representativeness is managed as part of the data collection.

The ACR suggests that you consider the following guidelines with regard to question composition. **Survey questions must be asked in an unbiased and balanced way and these questions should yield data that is analytically sound.** Additionally, ratio data is generally more powerful analytically than nominal data, while open-ended data can help characterize feedback but is of limited analytical usefulness.

Customer/Patient Evaluation measures are typically measures to assess overall evaluation and/or satisfaction with an experience. It is important to utilize a Likert scale (versus an open-ended or binomial response) for greater analytic power. Examples of suggested evaluative questions include Overall Rating and Satisfaction types. Expectations questions are an additional form of evaluative measure wherein a sample population utilizes a scale to measure how well an experience met with expectations. This type of question is clearly important if there are ongoing assumptions about an experience and/or if there have been communications ahead of the experience that are meant to improve the overall experience.

Another vector of assessing experience, overall, and/or by specific aspects of the experience are questions describing the respondents' experience. For this measure, the rows or attributes could include phrases or sentences (e.g., sentences that relate to 'Overall appointment/exam/procedure' or 'the time I spent waiting for my exam/procedure/etc.'). An example of this question could be "Please think now about [your recent experience or aspect of that experience]. For each, please indicate how you would rate your experience, using the scale below."

- 5 – Describes my experience extremely well
- 4 – Describes my experience moderately well
- 3 – Describes my experience adequately
- 2 – Does not describe my experience very well
- 1 – Does not describe my experience at all

Attributes that affect overall evaluation, such as perceptions of cost, quality, and care, follow-up can be assessed using satisfaction, expectations being met or not or describing experience.

While Likert scale data is the easiest to analyze, open-ended questions may also have value. Comments captured in open-ended questions often have insights not captured in the tightly defined questions with scales. Data from the open-ended questions could be aggregated over several years to define trends that may inform additional questions or areas of focus as part of an iterative process to improve patient experience surveys.

Proposal

CMS is seeking input on what approaches should be taken to get reliable performance information for patients using patient reported data, in particular at the individual clinician level. Given the current Tax Identification Number (TIN) reporting structure, are there recommendations for ensuring clinician level specific information into MVPs? Should clinicians be incentivized to report patient experience measures at the individual clinician level to facilitate patients making informed decisions when selecting clinician, and if so, how?

ACR Comments and Perspectives

For particular specialties such as radiology, it may be challenging to implement this given variability in volume of surveys at the individual clinician level. It may be less relevant for patients to have information regarding imaging services at the clinician level.

MVP as Permanent MIPS Participation Solution

Proposal

CMS is proposing to apply a new MVPs framework to future proposals beginning with the 2021 MIPS Performance Year. MVPs would utilize sets of measures and activities that incorporate a foundation of promoting interoperability and administrative claims-based population health measures and layered with specialty/condition specific clinical quality measures to create both more uniformity and simplicity in measure reporting. The MVP framework will also connect quality, cost, and improvement activities performance categories to drive toward value; integrate the voice of patients; and reduce clinician barriers to movement into Advanced APMs. Further, the MVP framework would reduce the number of performance measures and activities clinicians may select.

ACR Comments and Perspectives

To summarize the ACR's initial thoughts on the viability of MIPS Value Pathways, we believe, in concept, MVPs could accomplish CMS' goals for reducing burden and adjusting QPP-MIPS participation to make it more relevant and useful to both patients and clinicians. We do encourage CMS to continue working toward finalizing details of the MVP framework as a more holistic approach to the MIPS category requirements with a primary focus on delivery of care in an efficient, effective, timely, and patient-centered manner, while distancing the focus on a specific number of measures being reported and scored.

To reiterate, we also recognize that the MVP concepts and framework must incorporate some flexibility to account for variation in specialties' size, practice arrangements and uniqueness in care delivery that may make variant MVPs a necessity. Additionally, the ACR believes it necessary and strongly recommends that in its continued planning and conceptualization of MVPs that CMS maintain an option for MIPS participation in its current form. This is most important in order for specialties such as radiology to meaningfully participate in MIPS when they may not fit into an MVP framework due to potential lack of applicability of certain currently proposed elements. Further, it is important when running these systems in parallel to maintain equity or parity for MVP participation and MIPS participation, such as in terms of clinical reporting burden, likelihood of a score or improvement. The newer measures might be more advantageous to use.

Again, we appreciate CMS' goal of simplifying the program and applaud its efforts to date with the MVP concept and framework. We look forward to continued opportunities for input and feedback to CMS over the coming months.

MIPS: Quality Performance Category

Quality Category Weighting

Proposal

CMS proposes at § 414.1330(b)(4) that the quality category will comprise 40 percent of a clinician's final score for the 2020 MIPS performance year/2022 payment year. CMS proposes at § 414.1330(b)(5) that quality will comprise 35 percent of a clinician's final score for the 2021 performance year/2023 payment year; and CMS proposes at § 414.1330(b)(6) that quality will comprise 30 percent of clinician's final score for the 2022 performance year/2024 payment year.

ACR Perspective and Comments

The ACR believes that the gradual decrease in the quality category weight is fair for clinicians in light of the statutory requirements under which CMS must operate.

Data Completeness

Proposal

CMS proposes to increase the data completeness criteria to 70 percent for the 2020 performance year. CMS is also seeking comment on whether they should increase the data completeness threshold for quality measures that are extremely topped out.

ACR Perspectives and Comments

The ACR opposes increasing the data completeness threshold to 70 percent for all measures in the MIPS program. Achieving a 70 percent data completeness threshold would be particularly difficult and burdensome for many radiology groups. Most practices rely on the hospital(s) for which the group provides services to assist in data extraction from hospital systems for MIPS measure reporting. In many cases, the hospital does not have the same sense of urgency or motivation to build extraction methodology to enable data collection and reporting as does the radiology group. Such a request might be put in the hospital's IT work queue, but frequently the hospital places a higher level of priority on its own needs rather than the group's, and the radiology group's MIPS request may repeatedly be re-prioritized down the work list. This issue can be exacerbated based on the number of hospitals where a group practices. The more facilities with which a group works, the harder it could become to attain a 70 percent completeness rate across all sites that a TIN practices. This is even more burdensome for small and rural practices that may cover multiple hospitals in a wide geographic area. Additionally, if a

group begins providing services to a new hospital during the reporting year it can be difficult and burdensome to develop new processes at that facility for reporting that year. That in itself could prevent a group from meeting a 70 percent threshold.

Until there is more homogenous alignment across CMS physician and hospital quality reporting programs, disparate motivations for measure reporting will exist. **Because of these typical circumstances for a radiology group, the ACR urges CMS to keep the threshold at 60 percent.**

Data Completeness for Topped Out Measures

Proposal

CMS seeks comment on whether they should increase the data completeness threshold for extremely topped out quality measures that are retained in the program due to limited availability of measures for a specific specialty and potential alternative solutions in addressing extremely topped out measures.

ACR Perspectives and Comments

The ACR sees the benefit of raising the data completeness threshold for topped out measures if point caps are removed and the measures are maintained in MIPS.

This is an overlapping issue with the ACR's concerns with CMS' proposals for measure removal, as discussed in our comment document on that topic. To summarize those comments here, CMS topped out measure scoring and removal policies disproportionately impact radiology, which has the highest percentage (95 percent) among all specialties of topped out measures, with only a single non-topped out measure remaining for program year 2020. This asymmetry disproportionately impairs radiologists' MIPS flexibility and is anticipated to progress in ensuing years.

Removal of Quality Measures

Proposal

CMS proposes to add another criterion for quality measure removal if a quality measure is not available for MIPS quality reporting by all MIPS eligible clinicians. This action would target MIPS measure stewards that refuse to allow third party intermediaries, such as QCDRs and qualified registries, to use those measures for MIPS eligible clinicians. CMS is also interested in what factors should be considered in delaying the removal of measures.

CMS also seeks comment on whether it should delay the removal of a specific quality measure by a year and why.

ACR Perspective and Comments

The ACR agrees that MIPS quality measures should be available for all clinicians to report, regardless of their submission method. This prevents selection bias and allows clinicians to have more measures to report on if they are using a third party intermediary. **We suggest delaying the removal of measures if the measure can be related to an improvement activity or potentially cost, particularly with the proposed MVP framework that CMS is proposing.**

Quality Measures Proposed for Removal

Proposal

CMS has indicated their intent to remove several measures that are relevant to radiology, including the following:

Measure #146: Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening - CMS proposes to remove this measure because it is considered standard of care.

Measure #225: Radiology: Reminder System for Screening Mammograms - This measure is proposed for removal because CMS considers this a structure measure and not a patient outcome measure.

Measure #361: Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry - CMS proposes to remove this measure because they do not consider the quality action to be directly related to patient outcomes.

Measure #362: Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-Up and Comparison Purposes - CMS proposes to remove this measure for the same rationale as #361.

ACR Perspective and Comments

Availability of specialty specific measures for diagnostic radiology is in a critical state. 95 percent of radiology measures are topped out and 4 are proposed for removal in 2020 (146, 225, 361 and 362), with two removed in 2019 (359, 360). Please see Table 1 below for a complete list of radiology measures by status.

Table 1-Summary of MIPS Quality measures associated with diagnostic radiology (data from Journal of American College of Radiology paper in press Jan 2020 - *The Quality Measure Crunch: How CMS Topped Out Scoring and Removal Policies Disproportionately Disadvantage Radiologists.*)

ID	Name	Collection type	Benchmark	Avg	SD	Topped out in 2018	Topped out in 2019	Capped in 2019
145!	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Claims	Y	81.9	26.5	No	Yes	No
145!	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Registry	Y	85.1	24.9	No	Yes	No
146!	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms	Claims	Y	0.3	1.2	Yes	Yes	Yes
146!	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms	Registry	Y	0.5	3.5	Yes	Yes	Yes
147!	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	Claims	Y	86.2	22.3	No	Yes	No
147!	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	Registry	Y	94.1	13.7	Yes	Yes	Yes
195	Radiology: Stenosis Measurement in Carotid Imaging Reports	Claims	Y	92.7	16.1	Yes	Yes	Yes
195	Radiology: Stenosis Measurement in Carotid Imaging Reports	Registry	Y	96.6	10.7	Yes	Yes	Yes
225	Radiology: Reminder System for Screening Mammograms	Claims	Y	94.3	19.3	No	Yes	Yes
225	Radiology: Reminder System for Screening Mammograms	Registry	Y	97.4	13.8	Yes	Yes	No

360!	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	Registry	Y	75.9	34.1	--	Yes	No
361!	Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry	Registry	Y	96.5	14.3	--	Yes	No
362!	Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison	Registry	Y	94.4	21.9	--	Yes	No
364!	Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	Registry	Y	84.6	25.3	--	Yes	No
405!	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	Claims	Y	7.8	16.7	No	Yes	No
405!	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	Registry	Y	5.8	9.8	No	Yes	No
406!	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	Claims	Y	31.2	34.7	No	No	No
406!	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	Registry	Y	9.4	18.2	No	Yes	No
436!	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Claims	Y	88.4	23.3	No	Yes	No

436!	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Registry	Y	92	20.2	No	Yes	No
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! High priority measures

Against this backdrop, many high-performing measures are still showing a low adoption rate among radiologists, thus a reason for the high performance score may be a result of a small pool of high performing individuals choosing to report certain measures. This would skew the average score and mask the actual performance gap more than if the measure was reported across a larger number of practices, including those with worse performances on the measures in question. Please see Table 2 below for reporting trends through 2016 for radiology measures. Seven of 13 measures have a reporting rate less than 50 percent, one has under 70 percent; the remaining 5 were part of a measures group until 2017, thus the reporting rate information is not comparable.

Table 2-Diagnostic Radiology Measures Reporting Trends and Performance Scores used for 2019 Performance Year Benchmarking (QPP reporting rates not available)

Measure Number	Measure Description	2013 Eligible to Report	2014 Eligible to Report	2015 Eligible to Report	2016 Eligible to Report	2013 Reporting Rate	2014 Reporting Rate*	2015 Reporting Rate*	2016 Reporting Rate*	Ave Perf score for 2019 BM (C, R)
145	Exposure Time Reported for Procedures Using Fluoroscopy	90,020	68,044	88,549	125,493	19.5%	25.5%	21.9%	15.7%	81.9/85.1
146	Inappropriate Use of "Probably Benign" (inverse)	19,286	16,274	22,142	25,328	57.8%	66.4%	52.6%	47.9%	0.3/0.5
147	Correlation with Existing Imaging Studies Bone Scintigraphy	15,185	13,197	15,204	16,612	65.4%	76.7%	70.6%	67.9%	86.2/94.1
195	Stenosis Measurement in Carotid Imaging Reports	53,084	43,438	49,002	59,440	31.5%	39.0%	38.7%	35.4%	92.7/96.6
225	Radiology: Reminder System for Screening Mammograms	21,678	17,725	22,150	25,330	41.7%	55.5%	48.9%	46.4%	94.3/97.4
360	Count of Potential High Dose Radiation Imaging Studies:	N/A	57	--	10	N/A	100.0%	--	100.0%	75.9/96.5
361	Reporting to a Radiation Dose Index Registry	N/A	--	--	--	N/A	--	--	--	--/96.5
362	(CT) Images Available for Follow-up and Comparison Purposes	N/A	63	94	10	N/A	100.0%	100.0%	100.0%	--/94.4
363	Search for Prior Computed Tomography (CT) Studies	N/A	63	55	6	N/A	100.0%	100.0%	100.0%	Removed in 2017

364	<i>Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules</i>	N/A	63	56	6	N/A	100.0%	100.0%	100.0%	--/84.6
405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions (inverse)	N/A	N/A	N/A	75,336	N/A	N/A	N/A	19.0%	7.8/5.8
406!	Appropriate Follow-up Imaging for Incidental Thyroid Nodules (inverse)	N/A	N/A	N/A	60,911	N/A	N/A	N/A	23.4%	31.2/9.4
436	Utilization of Dose Lowering Techniques in CT	N/A	N/A	N/A	66,921	N/A	N/A	N/A	32.0%	88.4/92.0

* Measures groups were available these years. This limited reporting requirement to 20 cases but for all measures in the measures group. Only reportable through a registry. The following measures were in the OPEIR measure group: 360, 361, 362, 363, 364 those years. Reporting rate for the measures in the measure group is not representative of the percent of radiologists who was eligible to report these measures. Not enough information available to determine CMS' methodology for calculating the reporting rate for measures groups.

! Only measure not topped out and only for claims reporting.
All measures except 195 and 225 are high priority or outcome.

The newer radiology measures (405, 406 and 364) and several interventional radiology measures (i.e. 409, 421) have low reporting rates, in part due to difficulty in data collection where extraction from the radiology report is required – also a data completeness issue. And yet these measures are considered topped out. Technology that supports easier extraction of data (structured report tools, natural language processing) is quickly evolving, thus it is likely that reporting these measures may be on the rise; it is premature to remove these since increased reporting may result in a greater variation in performance.

CMS' rationale for removing some measures (i.e. 361 and 362) is that the measures are process/structural or not directly related to patient outcome. This is especially problematic for radiology in that imaging services are typically provided at an early stage of the care process, and process measures support care improvement across the care continuum. Additionally, both of these measures were part of the Optimizing Patient Exposure to Ionizing Radiation Physician Quality Reporting System (PQRS) specialty measures group until MIPS began in 2017. The performance data on which these have been assessed is largely based on the limited number of cases (20) required to be reported when using a measures group. This skews the actual performance gap toward higher scores from higher performing groups.

Two measures (146 and 225) proposed for removal are specific to radiologists performing screening mammography. Removal of the two breast imaging measures would leave many groups/eligible clinicians (ECs) who only have a case mix relative to these mammography measures (typical in community and rural settings) without any practice-relevant measures to

report. This would mean independent mammography practices' participation in MIPS would be limited to Improvement Activities, since these practices are in effect exempt from Promoting Interoperability and Cost categories. Additionally, breast cancer screening may be ideal as an initial concept for a radiology MIPS Value Pathway (MVP). The ACR has seen breast cancer screening as one area most feasible in a bundled payment framework due to a distinct episode of care (screening event to one year out/positive diagnosis).⁵

With the potential for a screening mammography MVP, it would be premature to remove both 146 and 225 from MIPS in 2020 and important to keep breast imagers engaged in MIPS until such time an MVP could be designed, rather than having the measures in one year, out the next and potentially back into the program. While the performance scores for these measures are very high, 1) the number of eligible radiologists who report them is less than 50 percent of those who could, based on available CMS data through 2016; 2) 146 is a process measure that indicates radiologists are using standardized lexicon and guideline-based recommendations appropriately/225 ensures care coordination and follow up with a patient to stay on track with recommended screening intervals; and 3) the attractiveness of MVPs includes the ability to evaluate care provided at a more macroscopic level where hopefully "topped out" status of measures does not have as significant of an impact. Process measures such as these remain important and would be vital in an MVP.

The above discussion illustrates the effect of removing two radiology measures in 2020. Perhaps more concerning is the trajectory for virtually the rest of currently available measures to radiologists. As mentioned above, 95 percent of radiology measures are currently topped out with only one remaining as not topped out and only for claims reporting (406). All but two of the topped out/proposed for removal measures are high priority or outcome (only 195 and 225 are not). See Table 1 above (! indicating high priority measures). If only topped out/capped measures are available to radiologists, and with no high priority measures available, even the highest scoring performers will receive a score lower than maximum of 60 points in the Quality category. And, since the Quality is the most heavily weighted category for radiologists' final score (typically 85 percent of most radiologists' final score due to reweighting from PI and Cost), the difference between 7 and 10 points on each of the 6 required quality measures will result in a significantly lower quality category score, a significantly lower final score and resulting in payment adjustment disparities or inequity across specialties.

The ACR is very actively developing new measures that could be implemented first in our Qualified Clinical Data Registry (QCDR) (7 new proposed with our 2020 self-nomination), with the goal of eventual implementation as CQMs. However, it is a years-long process to do so. Additionally, even as new radiology measures are added to MIPS, the lack of initial years' benchmarks limits the number of MIPS points that radiologists could obtain.

⁵ Hughes DR, Jiang M, McGinty G, Shetty SK, Duszak R. An empirical framework for breast screening bundled payments. *J Am Coll Radiol* 2017;14:17-23 e1.; and Digital Breast Tomosynthesis Implementation: Considerations for Emerging Breast Cancer Screening Bundled Payment Models Fleming, Margaret M. et al. *J Am Coll Radiol*, Volume 16, Issue 7, 902 – 907

The ACR highly recommends that CMS not cap measures unless a specialty has at least 6 non-capped measures they can report. With the projected timeline of removal of topped out measures, as CMS removes radiology measures in coming years, more and more radiologists are likely to not have six quality measures to report. **We also suggest delaying the removal of measures if the measure can be related to an improvement activity or potentially a cost measure,** in consideration of their potential use within the proposed MVP framework. **Additionally, we suggest that CMS take into consideration the measure reporting rate (uptake, not data completeness) and not mark a measure as topped out unless a certain percentage of reporting is met, perhaps 50 percent.**

Call for Measures

Proposal

CMS proposes that beginning with the 2020 Call for Measures process, MIPS quality measure stewards would be required to link their MIPS quality measures to existing and related cost measures and improvement activities, as applicable and feasible. MIPS quality measure stewards would be required to provide a rationale as to how they believe their measure correlates to other performance category measures and activities as a part of the Call for Measures process.

CMS also seeks comment as to whether it should consider realigning the MIPS quality measure update cycle with that of the eCQM annual update process.

ACR Perspective and Comments

The ACR believes that linking new quality measures with improvement activities and/or cost measures is a useful concept, but urges CMS not to make it a mandatory practice. There could be measures that represent a high quality action, but might not be able to be linked to another category. It could become a deterrent rather than an improvement. Additionally, it may be difficult to link all specialty-specific quality measures to cost measures in the case where there are no or limited cost measures attributable to a specialty. Potentially, measure stewards could identify how a quality measure might relate to cost efficiency without necessarily linking it to a specific existing cost measure.

Performance Threshold

Proposal

CMS proposes to raise the performance threshold to 45 points for 2020 and 60 for 2021 (from 30 points in 2019) with the exceptional performance bonus threshold set to 80 points for 2020 and 85 for 2021.

ACR Perspectives and Comments

The ACR agrees with raising the performance threshold to 45 points for 2020 and 60 for 2021 but disagrees with setting an exceptional bonus threshold beyond 80 points for 2021. The ACR suggests setting the exceptional bonus threshold year-by-year, based on the results from the previous performance year, rather than setting an arbitrary threshold for a future program year. The removal of quality measures affects clinician’s performance in the program, and it would be more equitable to see how performance scores average out for each program year before setting a threshold.

MIPS: Promoting Interoperability Performance Category

Promoting Interoperability: Automatic Reweighting of Non-Patient Facing Groups
Proposals

CMS proposes to re-establish automatic reweighting of the Promoting Interoperability category for “non-patient facing” groups (75 percent or more eligible clinicians in the associated TIN are non-patient facing).

ACR Perspectives and Comments

The ACR supports automatic reweighting from the Promoting Interoperability category for any group/virtual group that meets the non-patient facing definition under §414.1305. These groups have been automatically reweighted in all previous MIPS performance years, and an unfortunate drafting error in the 2019 PFS final rule would have inappropriately disallowed this methodology. If left uncorrected, this error would have created an undue regulatory burden for non-patient facing groups/virtual groups. **Therefore, the ACR supports modifications to §414.1380(c)(2)(iii) to address the 2019 error and explicitly clarify that non-patient facing groups (as defined under §414.1305) will continue to be automatically reweighted from the Promoting Interoperability category of MIPS as in the previous years of the program.**

Promoting Interoperability: Hospital-Based Groups/Virtual Definition

Proposals

Beginning with the 2020 performance year, CMS proposes to revise the definition of a “hospital-based MIPS eligible clinician” at § 414.1305 to include groups and virtual groups, provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period.

ACR Perspectives and Comments

The ACR supports CMS’ proposal to modify the “hospital-based MIPS eligible clinician” definition at §414.1305 to allow groups/virtual groups with greater than 75 percent hospital-based NPIs in the associated TIN(s) to obtain the “hospital-based” special status. Doing so would more appropriately align the various special statuses in the program and allow for variability in predominantly hospital-located groups/virtual groups. **However, the ACR recommends that this revised methodology be effective with the current (2019) MIPS performance year to maximize flexibility and reduce clinician burden.**

Promoting Interoperability: Request for Information (RFI) on the Provider to Patient Exchange Objective

Proposals

CMS requests information from stakeholders on the Promoting Interoperability “Provider to Patient Exchange” objective and various related considerations.

ACR Perspectives and Comments

The ACR recommends that CMS work with specialty societies to implement appropriate health information exchange activities (for example, imaging sharing without physical media) as optional alternatives to MIPS Promoting Interoperability compliance requirements. These alternative data-sharing activities could use FDA-regulated medical devices and other specialized IT solutions not currently certified under ONC’s certification program, and thus the “certified EHR technology (CEHRT)” definition under §414.1305 should also be modified to allow these solutions to be deemed CEHRT by CMS.

MIPS: Improvement Activities (IAs) Performance Category

IA Requirements

Proposal

CMS proposes to increase the minimum number of clinicians in a group or virtual group who are required to perform an improvement activity to 50 percent beginning with the 2020 performance year and future years. CMS also proposes that at least 50 percent of a group’s NPIs must perform the same activity for the same continuous 90 days in the performance period beginning with the 2020 performance year.

ACR Perspective and Comments

Although ACR agrees with CMS’ intention to raise the group reporting rate for improvement activities, **ACR believes that 50 percent may be too drastic of an increase.** We believe there is also an opportunity to designate some IAs as applicable to an entire group while some could be

designated as specific to an individual. **With many IAs, there is ambiguity regarding how to quantify physician participation, and establishing a 50 percent participation requirement could create some confusion.** Implementing a percentage requirement also somewhat underestimates the role and impact of a lead quality improvement clinician in a group. Their work typically affects all clinicians in the group. A percentage requirement will increase the documentation burden by requiring roll call at meetings and tracking participant's involvement. A single clinician can achieve the same goal for an entire group. However, if a participation threshold must be set, we would advise something lower than 50 percent, perhaps between 10 percent and 25 percent.

MIPS: Cost Performance Category

Total Per Capita Cost (TPCC) Measure

Proposal

CMS proposes the following changes to the Total Per Capita Cost (TPCC) measure: Changing the attribution methodology to more accurately identify a beneficiary's primary care relationships, changing the attribution methodology to more accurately identify clinicians who provide primary care services, by the addition of service category exclusions and specialty exclusions; changing the risk adjustment methodology to determine a beneficiary's risk score for each beneficiary-month using diagnostic data from the year prior to that month rather than calculating one risk score for the entire performance period using diagnostic data from the previous year; add an institutional risk model to improve risk adjustment for clinicians treating institutionalized beneficiaries; and changing the measure to evaluate beneficiaries' costs on a monthly basis rather than an annual basis.

ACR Perspective and Comments

The ACR strongly agrees with CMS' decision to include diagnostic and interventional radiology specialty exclusions in the revised TPCC measure. The ACR appreciates the extensive review of this measure and feels that the revised measure will more accurately represent primary care relationships.

Medicare Spending Per Beneficiary Measure (MSPB)

Proposal

CMS proposes the following changes to Medicare Spending Per Beneficiary (MSPB): Changing the attribution methodology to distinguish between medical episodes (where the index admission has a medical Medicare Severity Diagnosis Related Group (MS-DRG) and surgical episodes (where the index admission has a surgical MS-DRG), to add service exclusions to remove costs that are unlikely to be influenced by the clinician's care decisions, and to modify the measure title from Medicare Spending Per Beneficiary (MSPB) to Medicare Spending Per Beneficiary

clinician (MSPB clinician) to distinguish it from measures with similar names in use in other CMS programs.

ACR Perspective and Comments

The ACR supports the measure name change to differentiate the previous MSPB measure from the new proposed measure. This will make benchmarks and reports easier to understand when comparing measures. The ACR appreciates the proposed service exclusions that remove unnecessary costs.

MIPS: Qualified Clinical Data Registry (QCDR)

QCDR Performance Category Submission

Proposal

CMS proposes to amend § 414.1400(a)(2) to state that beginning with the 2021 performance period and for all future years, for the MIPS performance categories identified in the regulation, QCDRs and qualified registries must be able to submit data for each category, and Health IT vendors must be able to submit data for at least one category. CMS solicits feedback on the benefits and burdens of this proposal, including whether the requirement to support all three identified categories of MIPS performance data should extend to health IT vendors.

ACR Perspective and Comments

ACR supports CMS' proposal to require QCDRs to submit data for each performance category, but we acknowledge that supporting all MIPS performance categories may be burdensome for certain QCDRs. CMS has also given MIPS-eligible clinicians the ability to report using multiple collection types, so in the event that a QCDR does not support all categories, their clinician users would still have the opportunity to report the remaining categories using other mechanisms. While this rule would not negatively affect ACR's QCDR, we would like to defer to the consensus.

Self-Nomination – Educational Services

Proposal

CMS proposes to add § 414.1400(b)(2)(iii) that beginning with the 2023 MIPS payment year (2021 performance year), the QCDRs must foster services to clinicians and groups to improve the quality of care provided to patients by providing educational services in quality improvement and leading quality improvement initiatives. CMS would require QCDRs to describe the quality improvement services they intend to support in their self-nomination for CMS review and approval. CMS intends on including the QCDR's approved quality improvement services in the qualified posting for each approved QCDR.

ACR Perspective and Comments

The ACR appreciates CMS' recognition of the value in aligning quality improvement initiatives and resources with participation and feedback that clinicians receive from a QCDR. The integration of structured quality improvement templates or projects, educational resources and a learning community space is a short- and long-term goal that ACR has identified for the National Radiology Data Registry (NRDR). **However, we believe that it is premature to implement this as a requirement for QCDR approval at this time, and particularly infeasible to do so as early as 2021.**

The processes and resources required to develop these sorts of products and services within a specialty society are likely to a great extent the responsibility of staff not directly involved in QCDR activities. In that situation, such development efforts would require budgeting, planning and coordinating across staff or departmental areas that may not already be in place. It also requires involvement from physician/clinician volunteers to direct and guide activity development.

QCDR Measure Approval

Proposal

Beginning with the 2020 performance period, CMS proposes that in considering whether to approve a measure, it may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the owner of the QCDR measure for purposes of MIPS. Under this proposal, CMS has the discretion to not approve a QCDR measure if it concludes that such measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs.

ACR Perspective and Comments

The ACR strongly opposes this proposal because it undermines QCDR measure ownership and development. As noted in our comments on the CY 2019 Quality Payment Program Proposed Rule, we strongly opposed CMS' proposal to require QCDRs to license their QCDR measures to CMS without charge and allowing the Agency to make them freely available to other QCDRs. CMS decided not to finalize this policy, likely due in large part to receipt of substantial negative feedback. Now CMS' current proposal to consider the availability of measures to other (non-owner) QCDRs as a condition of measure approval appears as a backdoor effort to accomplish the same mandatory licensing policy that CMS proposed (but did not finalize) last year. The outcome would be the same as with the CMS 2019 proposal, in that it would remove a QCDR's right to control the use of their measures, place conditions on use of the measure by other QCDRs or to collect a reasonable royalty from other qualified QCDRs that wish to use them.

Accordingly, we urge CMS to not adopt its proposal to withhold measure approval based on the extent to which a QCDR makes its measures available to other QCDRs. At a minimum, it should elaborate on what criteria it would use to determine whether a measure is truly unavailable for reporting through other QCDRs. Additionally, CMS should provide an opportunity for QCDR measure owners to respond to allegations of unavailability before this is allowed to be a consideration in the measure approval process.

Linking QCDR Measures to Cost Measures, Improvement Activities or an MVP

Proposal

CMS proposes that, beginning with the 2021 performance period, QCDRs must “link their QCDR measures to the following at the time of self-nomination: (i) Cost measure, (ii) improvement activity, (iii) an MVP.

ACR Perspective and Comments

The ACR believes that this proposal would cause additional burden on QCDRs at a time when CMS has made a number of other proposals for additional QCDR requirements. It is also premature to require such a linkage with MVPs when the concept and framework for MVPs is in its infancy.

Additionally, CMS has not provided guidance to QCDRs regarding how they should “identify a linkage” between all three items. Moreover, we are concerned that this proposal is effectively equating health care costs to quality. We do, however, appreciate CMS’ recognition that not all measures may have a direct link. We agree with CMS that an exception should exist in cases where a QCDR measure lacks a clear link to a cost measure, improvement activity, or an MVP. Even though CMS does recognize that not all measures may have a direct link we do not support this proposal at this time. We agree with CMS that an exception should exist in cases where a QCDR measure lacks a clear link to a cost measure, improvement activity, or an MVP.

QCDR Feedback

Proposal

CMS proposes a change so that QCDRs structure feedback in a similar manner. CMS proposes a new paragraph at § 414.1400(b)(2)(iv), beginning with the 2023 MIPS payment year [2021 performance year], to require that QCDRs provide performance feedback to their clinicians and groups at least 4 times a year, and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the QCDR. Exceptions to this requirement may occur if the QCDR does not receive the data from their clinician until the end of the performance period. CMS solicits comment on other exceptions that may be necessary under this requirement.

ACR Perspective and Comments

The ACR supports CMS’ proposal to require QCDRs to provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the QCDR at least 4 times a year. We agree that there should be an exception if the QCDR does not receive the data from their clinician until the end of the performance period. However, we also suggest that participants who are enrolled in the QCDR but who have not yet submitted data could still receive a comparative feedback report for registry performance as a whole. This would at least give the participants an idea of the performance rates to which they would be compared and also may serve as encouragement to submit data as soon as possible.

Clinician Submission to QCDRs

Proposal

CMS seeks comment for future rulemaking on whether it should require MIPS eligible clinicians, groups, and virtual groups who utilize a QCDR to submit data throughout the performance period, and prior to the close of the performance period (i.e., December 31). CMS also seeks comment for future rulemaking on whether clinicians and groups can submit their data starting April 1 to ensure that the QCDR is providing feedback to the clinician or group during the performance period. This would allow QCDRs some time to provide enhanced and actionable feedback to MIPS eligible clinicians prior to the data submission deadline.

ACR Perspective and Comments

The ACR agrees with the requirement of data submission prior to the close of the performance period, **but would like to suggest that clinicians be required to submit data by January 31 rather than December 31.** Imposing a requirement that all data need to be submitted by the last day of the performance period might be too burdensome for the clinician, especially if they are struggling with obtaining their data from their institution. We feel that providing an extra month of time might be a better way to ease clinician groups into becoming more actionable with data submission. We also seek clarification on what CMS means by “throughout the performance period.” Practically speaking, when a new performance year begins, many groups who use our QCDR are unable to begin submitting data immediately.

Along these same lines, **ACR disagrees with the suggestion of April 1 as a deadline for clinicians to begin submitting MIPS data to QCDRs.** Many of our users experience difficulty in transitioning to a new year of MIPS reporting, and in many cases it takes several months for them to begin submitting data with regularity, particularly for new sites or when reporting data for an additional National Radiology Data Registry (NRDR) database. ACR also has many users who elect to submit via QCDR later in the year after weighing submission mechanism options, and it is not clear how this sort of rule might affect users like them.

QCDR Measure Testing and Data Collection Self-Nomination Requirements

Proposal

CMS proposes, at § 414.1400(b)(3)(v)(C), that beginning with the 2021 performance period, all QCDR measures must be fully developed and tested, with complete testing results at the clinician level, prior to submitting the QCDR measure at the time of self-nomination. Additionally, CMS proposes that for a QCDR measure to be considered for use in the program, beginning with the 2021 performance period and future years, that QCDRs are required to collect data on a QCDR measure, prior to submitting the QCDR measure for CMS consideration during the self-nomination period. The data collected must demonstrate whether the QCDR measure is valid and reflects an important clinical concept(s). CMS suggests and strongly encourages QCDRs collect data for 12 months prior to self-nomination.

ACR Perspective and Comments

The ACR recognizes the value in collecting performance and test data on new measures as early as possible and understands that doing so might more definitively indicate the readiness and feasibility of those measures.

However, the ACR believes that the requirement to collect data for 12 months prior to self-nomination of a measure is an unrealistic and unduly burdensome deadline for QCDRs.

Implementing new measures before they are available for MIPS credit greatly reduces the likelihood that clinicians or groups will submit data on them. A few early adopters may be interested in doing so but that provides only limited data with which to calculate a performance gap. It is also similar to new MIPS CQMs where reporting rates may be low for one or two reporting cycles until practices gain experience with how to code for or collect data for the new measure.

Perhaps a testing/provisional status might be feasible, in which CMS would allow credit of some sort for reporting such measures, such as a base 3-5 points or fully meeting improvement activity requirements.

MIPS: Targeted Review

Third Party Intermediaries

Proposal

CMS proposes to revise § 414.1385(a)(1) to state that a MIPS eligible clinician or group (including their designated support staff), or a third party intermediary as defined at § 414.1305 (e.g., a qualified registry, health IT vendor, or QCDR), may submit a request for a targeted review.

ACR Perspective and Comments

The ACR strongly agrees with this proposal. Particularly with QCDR measures, the third party intermediary may have more knowledge on how the measure score was miscalculated and what verbiage to provide in the targeted review. This would be beneficial both to CMS and to the clinician.

Submission Period

Proposal

CMS proposes to revise § 414.1385(a)(2) to state that all requests for targeted review must be submitted during a 60-day period that begins on the day CMS makes available the MIPS payment adjustment factors, and to state that the targeted review request submission period may be extended as specified by CMS. This change would apply beginning with the 2019 performance period.

ACR Perspective and Comments

The ACR agrees with this proposal. 60 days is a reasonable amount of time to submit a targeted review.

Documentation

Proposal

To align with policies regarding the auditing of entities submitting MIPS data, CMS also proposes to add § 414.1385(a)(8) to state that documentation submitted for a targeted review must be retained by the submitter for 6 years from the end of the MIPS performance period.

ACR Perspective and Comments

The ACR supports this proposal. It is important for the submitter to maintain records of their MIPS data to ensure the most accurate targeted review.

Medicare Shared Savings Program (MSSP)

Alignment of MSSP Quality Score and MIPS Quality Score

Proposal

CMS is soliciting comments on how to potentially align the Medicare Shared Savings Program (MSSP) quality reporting requirements and scoring methodology more closely with the MIPS quality reporting requirements and scoring methodology. First, CMS is requesting comments on

replacing the MSSP quality score with the MIPS quality performance category score, for Accountable Care Organizations (ACOs) in MSSP tracks (or payment models within a track) that do not meet the definition of an Advanced APM (currently, Track 1 and BASIC Track Levels A, B, C and D). CMS also welcomes comment on the approach of using the MIPS quality performance category score to assess quality performance for purposes of the MSSP quality performance standard for ACOs that are in tracks (or payment models within a track) that qualify as Advanced Alternate Payment Models (APMs). CMS also welcomes comment on potential alternative approaches for scoring MSSP quality performance in a way that more closely aligns with MIPS.

ACR Perspective and Comments

We support the CMS proposal to simplify the process for providers participating in MSSP or those providers in advanced APMs not meeting criteria to be a QP by using MIPS quality scores as the MSSP quality performance score. We believe this step reduces the complexity and burden of reporting.

Physician Compare

Physician Compare Final Scores

Proposal

CMS is proposing to begin reporting MIPS eligible physicians' overall MIPS final scores and individual performance category scores on the Physician Compare website, as well as aggregate MIPS data showing the range of overall MIPS performance scores and individual category scores.

ACR Perspective and Comments

ACR approves of CMS' efforts to improve Physician Compare, but we have concerns about including cost data as part of the Physician Compare scoring rubric, especially because that data could be misinterpreted by patients. CMS' method for calculating cost performance, while meaningful to physicians, may not be well understood by patients. We believe Physician Compare should place the highest emphasis on quality of care, with cost being secondary.

Establishing a Value Indicator

Proposal

CMS is also seeking comments on whether to establish a "value indicator" for MIPS-eligible physicians whose information is published on the Physician Compare website. This would

potentially be a numerical composite of their cost, quality, and patient experience and satisfaction scores, representing the overall value and quality of a physician's care.

ACR Perspective and Comments

ACR approves of the creation of a value indicator, but believes that CMS needs to clearly define the method of calculating this score and make these methods public. ACR would also like to emphasize that the Physician Compare website needs to be more transparent in general about how it populates physician performance data. In **speaking with our physician members, many of them have noted that their Physician Compare information is inaccurate or at the very least not representative of their true performance.** As such, this value indicator could either be a step in the right direction that helps clarify some of these issues, or it could lead to more inaccuracies and frustrations.

Conclusion

The ACR appreciates the opportunity to provide comments on the CY 2020 MPFS proposed rule. We encourage CMS to continue to work with physicians and their professional societies throughout the rulemaking process in order to create a stable and equitable payment system. The ACR looks forward to continued dialogue with CMS officials about these and other issues affecting radiology and radiation oncology. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Angela Kim at 800-227-5463 ext. 4556 or via email at akim@acr.org.

Respectfully Submitted,



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