December 30, 2004

Mark B. McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
File Code: CMS-1429-FC
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for calendar year 2005; Final Rule

Dear Dr. McClellan:

The American College of Radiology (ACR), representing over 32,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates many of the decisions outlined in the Medicare Fee Schedule (MFS) final rule for calendar year 2005 (42 CFR Parts 403, 405, 410, et. al.) and offers comments in the following areas:

- Five Year Review;
- Low Osmolar Contrast Media (LOCM);
- Professional Liability Insurance (i.e., Malpractice) Relative Value Units (RVUs);
- Section 952, Revisions to Reassignment Provisions;
- Positron Emission Tomography (PET);
- Category III Tracking Code 0073T;
- Change in Global Period for CPT Code 77427, Radiation Treatment Management, Five Treatments;
- Coding for Brachytherapy Sources under Medicare Part B in the Physician Office and Freestanding Radiation Oncology Center;
- Interim 2004 Codes, CPT Code 43752;
- Venous Mapping for Hemodialysis;
- Bone Marrow Aspiration and Biopsy through the Same Incision on the Same Date of Service;
- Repricing of Clinical Practice Expense Inputs, Equipment.

Five Year Review
The ACR appreciates CMS’ effort to ensure that physician work values in the Medicare Fee Schedule for all CPT codes are appropriate. The ACR submits the following codes and below stated rationale for the five year review.
Since cardiac Magnetic Resonance Imaging (MRI) was valued by the Relative Value Update Committee (RUC) in 1993, new technological advances have dramatically changed cardiac MR imaging. New pulse sequences and improvements in computer processing and MR cardiac gating has made dynamic imaging, quantitative analysis and physician involvement in post-processing of cardiac MR images a requirement for accurate diagnosis. When the codes were valued in 1993 only a few cardiac pulse sequences with limited post-processing were available. The emphasis at that time was on anatomy. With the advances in technology, physiologic assessment is now possible and is routinely used.

The ACR and American College of Cardiology (ACC) believe that the physician work has increased in all areas of the exam. Specifically, in the pre-service period for preparing protocols; in the intra-service period for monitoring, guiding and directing appropriate set-up of sequences and anatomy, post-processing and interpretation; and in the post-service period for review of cases with referring physicians. We believe this is new physician work, and that current work values do not accurately reflect the changes in physician work that have occurred since 1993.

The ACR and ACC question the accuracy and validity of the survey process in 1993. Cardiac MRI was very limited at that time and the pool of potential respondents was limited. The RUC database does not list the number of respondents; survey median RVU or other information that would allow us to validate the accuracy of the survey data. The times listed in the database are counterintuitive and at times inversely related to the physician work value. For example, code 75552 has physician work value of 1.6 RVU and survey time of 144 minutes. Code 75553 has physician work value of 2.0 RVU and survey time of 98 minutes. Our societies believe a new survey of this family of codes is required to determine accurate times and work values, and that the decision for placing these codes in the Five Year Review process and subsequent revaluation should not be biased by the previous survey result.
The ACR and ACC believe that there are rank order anomalies with existing codes. For example, physicians performing both MRI of the chest and cardiac MRI state cardiac MRI exceeds thoracic MRI in both physician time and intensity. Physicians performing both cardiac MRI and transthoracic echocardiography state that cardiac MRI exceeds transthoracic echocardiography in both physician time and intensity. These are anecdotal impressions from our members; however, the information suggests a new survey of this family of codes is in order.

While we appreciate CMS giving societies the chance to suggest an appropriate RVU for submitted procedures, we will not have a definite recommendation until we see our survey result. However, we anticipate that the values will be greater than the existing non-cardiac MRI and echocardiography codes.

**Low Osmolar Contrast Media**

The ACR applauds CMS’ decision to eliminate the restrictive criteria for payment of low osmolar contrast media (LOCM) which will assure universal coverage of LOCM for all Medicare beneficiaries as well as consistent policy across payment settings. The ACR further supports CMS’ sound decision to not apply the originally proposed eight percent reductions to the LOCM payment.

The ACR understands from its review of the final rule that CMS is exploring the possibility of developing additional HCPCS codes for the reporting of LOCM agents to capture the cost differences among contrast agents as well as the differing clinical uses, concentration, and dose administrations.

The ACR does not recommend the development of additional HCPCS codes to report LOCM and encourages CMS to continue to maintain (or further streamline) the existing HCPCS codes used to bill for low osmolar contrast agents (i.e., A4644, A4645 and A4646). The development of additional HCPCS codes would create an unnecessary administrative burden for practices and hospital based physicians who submit claims for this contrast media and would also create excessive granularity in the coding system. Alternatively to this, in our previous letter to CMS dated 03/15/04 we suggested that when establishing universal coverage of LOCM, a single code billed on a “per 50cc” increment would be most effective.

We believe it will be important for CMS to provide preliminary payment rates for LOCM prior to their implementation on April 1, 2005. This was done with many other drugs whose new payment rates will become effective on January 1, 2005 and it proved to be a useful means for identifying and correcting potential problems before the payment rates became effective. At the time preliminary payment rates for LOCM become publicly available, we will be able to evaluate the adequacy of the payment rates and we will be in a better position to determine whether simplification of the codes will be beneficial to our members and to CMS.

**Professional Liability Insurance (i.e., Malpractice) Relative Value Units (RVUs)**

The ACR appreciates CMS maintaining the current charge based malpractice RVUs for technical component services that do not have physician work until an alternative methodology is identified to establish resource based RVUs for technical component services. The ACR looks forward to working with CMS in this regard and would also like to maintain an open dialogue regarding the ACR’s concern over the imbalance in the distribution of malpractice RVUs to the professional component and technical component of a service.
Section 952, Revisions to Reassignment Provisions
The ACR appreciates CMS’ recognition that the new reassignment exception for contractual arrangements will potentially permit numerous relationships and financial arrangements which may result in an increased potential for fraud and abuse activity. Thus, we applaud CMS’s efforts to assure that the reassignment exception is consistent with current self-referral and anti-kickback statutes.

Positron Emission Tomography (PET)
The 2005 edition of Current Procedural Terminology (CPT) includes new category I CPT codes for PET and PET/Computed Tomography (CT) tumor imaging, 77881-77886. In accordance with established payment policy process, each of these codes was surveyed for by the ACR and the Society of Nuclear Medicine and presented at the RUC, which then forwarded physician work RVU recommendations and appropriate practice expense inputs to CMS. CMS agreed with the RUC’s determinations. The ACR was disappointed that CMS did not subsequently publish in this final rule the technical and global RVU’s for CPT codes 78811-78816 regardless of its position on the use of these codes. The ACR would like to continue a dialogue with CMS regarding PET and PET/CT.

Category III Tracking Code, 0073T
In this final rule CMS established practice expense and malpractice RVUs for 0073T (compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session) by crosswalking the category III code for compensator based beam modulation to the practice expense and malpractice RVUs assigned to CPT code 77418. The ACR disagrees with this crosswalk as the equipment costs of these two services are substantially different. In addition, this crosswalk contradicts the purpose of establishing the category III code, as the intent of 0073T was to make a distinction from 77418 and to collect cost data for compensator-based beam modulation treatment delivery in order to define the technical application and to determine the appropriate practice expense value of this service. The ACR requests that CMS discontinue the use of 77418 practice expense and malpractice values as a basis for 0073T pricing. In addition, the ACR recommends that 0073T continue to be carrier priced since a specific crosswalk cannot be suggested.

Category III codes have typically been carrier priced. The ACR realizes that CMS indicated in its 2004 physician fee schedule final rule that they would begin to establish crosswalks for certain category III codes or establish pricing information through use of cost data, typically at the request of a Carrier Medical Director (CMD). However, CMS also indicated in its 2004 final rule that they would work with the specialty societies to develop appropriate crosswalks for category III codes when CMS determined it was necessary to do so. The ACR is also concerned that the decision was made to crosswalk 0073T to 77418 without consulting the affected specialty societies. The ACR is available to continue to work with CMS on cross walking category III codes in general.

Coding Issues and the Change in Global Period for CPT Code 77427, Radiation Treatment Management, Five Treatments
The ACR greatly appreciates CMS’ consideration of the College’s proposed rule comments and decision to retain the global period of ‘xxx’ for CPT code 77427.
Coding for Brachytherapy Sources under Medicare Part B in the Physician Office and Freestanding Radiation Oncology Center

The ACR appreciates CMS reinstating HCPCS code Q3001 for (radioelements for brachytherapy, any type, each,) so that payment can be made under the physician fee schedule. The reinstatement of HCPCS code Q3001 for the reporting of brachytherapy sources will help assure a smooth transition when CPT 2005 becomes effective and code 79900 is no longer available for use.

Interim 2004 Codes, CPT Code 43752 Naso-or oro-gastric tube placement, requiring physician’s skill and fluoroscopic guidance

The ACR wishes to thank CMS for reconsidering of the 0.68 interim works Relative Value Unit (RVU) assigned to CPT code 43752 and agrees with the new assigned work RVU of 0.81 for this service.

Venous Mapping for Hemodialysis

In this final rule, CMS established a G code (G0365) to report mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow) and revised the originally proposed descriptor to enable clinicians, other than the operating surgeon, the opportunity to bill for this service. The ACR appreciates this revision.

CMS also indicates that they will not permit separate payment for CPT code 93971 when this G-code is billed, unless CPT code 93971 is being performed for a separately identifiable indication in a different anatomic region. In addition, CMS indicates that other imaging studies may not be billed for the same site on the same date of service unless an appropriate “KO” modifier indicating the reason or need for the second imaging study is provided on the claim form. It is important for CMS to understand the impact of this policy on the practice of radiology as radiologists only perform venous imaging on the day of a vascular access procedure, if requested to do so by the surgeon. When such a referral is made, the radiologist often does not have information of the details (from the referring physician) of the surgery itself or whether imaging was performed as part of that procedure. Therefore, the requirement for the modifier and associated explanation is not reasonable when the services are performed by a provider or practice other than the surgeon. Such restrictions may limit the access of Medicare beneficiaries to the rare but occasionally necessary imaging required after conduit placement.

Bone Marrow Aspiration and Biopsy through the Same Incision on the Same Date of Service

As outlined in the rule, CMS established a new add on G-code, G0364 (bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service) for the use with bone marrow biopsy code 38221 (biopsy, needle or trocar). The G-code, G0364 would be used for the second procedure (bone marrow aspiration), rather than reporting existing CPT code 38220 (bone marrow; aspiration only) as CMS felt that even with the application of the multiple procedure reduction rule to codes 38220 and 38221, they would be overpaying for these services when performed on the same day, at the same encounter using the same incision. The ACR does not agree with the creation of new G codes when there are existing CPT codes which accurately identify the service performed.
Repricing of Clinical Practice Expense Inputs, Equipment

The ACR appreciates CMS’ willingness to work with the ACR to document room pricing and other equipment costs. As per our discussion with CMS staff, we will provide documentation on outstanding items by March 2005.

Thank you for this opportunity to comment on the 2005 Medicare fee schedule final rule. The ACR looks forward to continued dialogues with CMS officials. Should you have any questions on the items addressed in this comment letter, or with respect to radiology and radiation oncology, please contact Rachel Kramer at the ACR offices. Rachel may be reached at 1-800-227-5463 ext. 4559 or via email at rachelk@acr.org.

Respectfully Submitted,

Harvey L. Neiman, M.D., FACR
Executive Director

cc: Herb Kuhn, CMS
Ken Simon, MD, CMS
Carolyn Mullen, CMS
Pamela J. Kassing, ACR
Rachel S. Kramer, ACR