January 10, 2011

Dear ACR Member:

Many ACR members are understandably concerned by the marked reductions in Medicare payment for computed tomography (CT) scans of the abdomen and pelvis. The new Current Procedural Terminology (CPT®) codes for CT abdomen and pelvis bundle the single body region codes for both procedures into a single code when both regions are examined in the same session. The codes were published in the new CPT 2011 code book for use beginning January 1, 2011. Values for the codes were released in the Final Rule for the Medicare Physician Fee Schedule (MPFS) Nov. 3, 2010, but due to fee schedule adjustments via Congressional action on the conversion factor, the final payment rates were only recently released.

We share frustration that the CPT Editorial Panel, the Relative Value Scale Update Committee (RUC) and the Centers for Medicare and Medicaid Services (CMS) did not accept ACR recommendations to maintain separate coding and valuation. In addition, CMS further reduced the technical component values to the absurd point where the bundled code is paid at nearly the same rate as the single region codes. For more than five years, ACR has strongly opposed the bundling of these CPT codes, whose sole purpose is to reduce payments for imaging services, even at the expense of proper coding.

What follows is a summary of why these CPT codes were selected for bundling, how the codes were developed and valued, and why payment rates could not be preserved.

**Background**

For many years, the Medicare Payment Advisory Commission (MedPAC) and the U.S. Government Accountability Office (GAO) have urged CMS to alter the Resource-Based Relative Value Scale (RBRVS) and to change the Medicare Fee Schedule to redistribute physician payments from specialists to primary care providers and other specialties that primarily perform Evaluation and Management (E&M) services. In its actions over the past five years, the United States Congress appears to have had a similar agenda.

When CMS proposed to assess the fee schedule for misvalued services and adjust values unilaterally, the physician community, through the AMA-Specialty Society Relative Value Update Committee, agreed to be part of the process to prevent CMS from acting independently and incorrectly. The RUC’s Relativity Assessment Workgroup (RAW) developed ways to look for potentially misvalued services, which is a government euphemism for “over-valued” services. One of the numerous “screens” developed by the RAW to look for misvalued services was to examine services reported using multiple
CPT codes. The first group of codes analyzed by the CPT Editorial Panel and the RUC were those that the Medicare database indicated were reported together greater than 90 percent of the time. That analysis found that, more than 90 percent of the time, when a CT pelvis is reported, a CT abdomen is also reported.

CPT Process

As early as 2005, the CPT Editorial Panel has been asked to create bundled codes for CT abdomen and pelvis. At the ACR’s urging, the CPT Editorial Panel rejected a payer submitted proposal for bundled CT abdomen and pelvis codes in order to maintain accurate coding. However, in 2008, the issue resurfaced as part of the CMS/RUC screens for misvalued services, and the CPT-RUC workgroup assigned to review the issues of multiple services recommended the CPT Editorial Panel create new bundled codes so that the combined service could be valued as a single unit by the RUC. The ACR again objected because for proper coding it would take up to nine bundled codes to accurately describe the various permutations of without and with contrast examinations that could be performed and urged the CPT Editorial Panel to reject the recommendation to create bundled codes. However, CMS and the RUC’s RAW insisted that these new codes be developed by CPT and valued by the RUC, stating payment policy concerns supersede accurate coding. The ACR staunchly opposed these changes for more than five years. If the ACR had not worked within the process, the codes would still have been created and the new values may have been developed even more quickly. Without radiology’s input through survey data and the RUC presentation process, the values could have certainly been lower.

RUC Valuation for Work and Practice Expense

ACR member surveys used for presentation at the RUC showed that the estimation of physician work relative value units (RVUs) was the same for the bundled code as the sum of services billed separately; however, the physician time elements from the surveys were not doubled. Therefore, the RUC held there was duplication of work when the two body regions were examined and voted for lower values. Although radiology has representation on the RUC, there are 27 other physician members of the RUC, many of whom are primary care physicians. In the final rule, CMS accepted these RUC recommendations, which reduced the physician work value of the CT pelvis portion of the examination by approximately 50 percent and ended up reducing payment for the combined services for the professional component by roughly 25 percent.

The ACR also submitted practice expense information for the direct practice costs of clinical labor time, supplies and equipment use for the new codes to the RUC’s Practice Expense Subcommittee. The review concluded that the additional labor time for the pelvis portion of the examination when performed with the abdomen was approximately 50 percent of the stand-alone CT pelvis code. These RUC modified inputs were sent to CMS for them to use in their practice expense formulae. Unfortunately, CMS is using practice cost data that was collected by the AMA using the Physician Practice
Information Survey (PPIS) in which office-based providers were woefully under-represented. Additionally, due to budget neutral adjustments in their methodology, only 50 cents on the dollar are paid for the direct practice costs.

The ACR has worked to correct or mitigate the effects of the flawed practice cost data, but CMS refused to modify the data or resurvey. Implementation of the practice cost data is being phased-in over four years. Providers will not see its full impact until 2013. However, CMS is implementing the fully transitioned values for all new CPT codes. Therefore, the full effect of the PPIS data and CMS-adjusted methodology are being felt immediately in the value of the new CT abdomen and pelvis codes. The CMS interim values for the new CT abdomen and pelvis codes were first made available in the MPFS final rule, published in November. The ACR cannot share results of the RUC process until publication of the CMS final rule under terms of a strict confidentiality agreement. We completed our analysis of all the radiology issues in the final rule and filed comments with CMS on Jan. 3, 2011. The ACR told CMS that it is poor policy not to phase-in the practice expense values for these new codes, which create rank order anomalies, until the practice expense transition is fully completed. For example, in 2011, the bundled codes have essentially the same technical component payment as the stand-alone CT abdomen code.

**Impact On Hospital Outpatient Payments**

CMS payment policy does not only affect physician office payments. CMS again ignored obvious additional costs for doing a pelvic CT scan with an abdominal CT scan when they placed the bundled codes in the same payment category (APC) as the single codes. In 2010, the CT abdomen and CT pelvis codes were paid under a bundled payment when done together on a patient under a composite APC at essentially double the value of the single body region codes. Under the new CMS payment policy, hospitals will see a 50 percent reduction in payment for performing the same work. The ACR commented to CMS on the issue of hospital payments as well.

**Moving Forward**

These changes are part of a larger effort by CMS, Congress, MedPAC, the GAO, the Office of Inspector General and other policy makers in Washington to find savings in the Medicare program and redistribute dollars to primary care providers. The health care reform bill gives the Secretary of Health and Human Services unprecedented authority to review relative values and cut payments to realize savings. To date, the bundled codes process has hit the cardiologists, radiologists and nuclear medicine physicians hard, as they suffered a 60 percent reduction in this same process in myocardial perfusion imaging codes last year (2010). In addition, the increase and expansion of the multiple procedure payment reduction rule has not only caused an additional hit to radiology, but also to physical therapists. In addition to the RUC recommendations for the CT spine, extremity and thorax codes, CMS did not accept a number of other RUC recommendations for services not involving radiology. In the proposed and final rules for
the MPFS, CMS discusses its search for other misvalued codes and new screens to identify additional services to be re-valued by the RUC. Some of these screens are codes with low RVUs but high utilization, codes billed 75 percent of the time together, and codes that have the largest growth in utilization in the Medicare database. The ACR is actively participating in these processes to ensure appropriate values for our services. Our representatives at CPT and the RUC are working tirelessly to advocate for radiology and maintain the relativity of our services with respect to other services in the MPFS.

Some have questioned whether radiology should continue participating in these activities that have a high likelihood of lowering reimbursement. Unfortunately, the process will continue whether we participate or not, and a negative outcome is not necessarily predetermined. For instance, based on our presentations, the RUC agreed not to alter values for a number of procedures including head and neck ultrasound and unenhanced CT of the spine, extremities and thorax. However, CMS disagreed with the RUC’s recommendation for the CT spine, extremity and thorax codes and unilaterally reduced the values. As detailed in our comment letter to CMS criticizing this decision, we plan to challenge CMS’s decision to reduce the RUC’s recommended values for these services in the Refinement Panel process, and we will likely have the backing of the RUC as we go forward. The process of identifying and revaluing potentially misvalued services is only beginning and will likely continue until alternate payment models are designed and implemented. If we are absent from the table on misvalued services, we may not have the credibility to advocate on other issues of importance to us as new payment system models are evaluated. We will continue to vigorously advocate on behalf of radiology and radiation oncology at CPT, the RUC, at CMS and with Congress to maintain the relativity of our services and practice expense payments.

We will continue to keep ACR members informed regarding these important issues, and at appropriate times, will ask some or all of you to call your legislators to help push our congressional agenda forward.

Bibb Allen Jr., MD, FACR
Chairman ACR Commission on Economics

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