ACR Comments to CMS on 2002 MPFS Final Rule

December 27, 2001

Thomas A. Scully, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room C5-14-03
7500 Security Boulevard
Baltimore, MD 21244-8013

Dear Mr. Scully:

The American College of Radiology (ACR) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) final rule on the Medicare Physician Fee Schedule for 2002, dated November 1, 2001. The ACR appreciates the positive responses to many of the comments filed by ACR regarding the proposed rule but has serious concerns with several remaining elements of the Medicare fee schedule. Specifically, the ACR is very concerned about the drastic reduction in the conversion factor and the code specific reductions in the practice expense RVUs for the majority of procedures performed by radiologists and radiation oncologists, as well as the reductions in mammography reimbursement.

The ACR appreciates CMS' actions on the following points, as detailed in this final rule. The ACR thanks CMS for reviewing and accepting the ACR’s comments and recommendations on the proposed rule regarding these issues.

- The establishment of new clinical wage rates for CT techs, MRI techs, medical physicists, and dosimetrists.
- The re-instatement of practice expense relative value units (PERVUs) for CPT code 76000 (fluoroscopy).
- The implementation of new physician work values for CTA, percutaneous vertebroplasty and abdominal aortic aneurysm (AAA) procedures.
- The retention of direct practice expense inputs for contrast agents proposed to be deleted.
- The decision to pay for emerging technology codes (category III codes) on a case-by-case basis. The ACR urges CMS to encourage CMDs to seriously consider coverage of category III codes as they are established.
- The willingness to work with the RUC and PEAC on practice expense refinement, as well as establishing revised PE values as "interim" until the refinement process is complete.
- The decision to accept practice expense supplemental surveys for an additional two years.
- The clarification on telehealth services as it relates to imaging.
- The decision to recognize FDA approval of CAD for diagnostic mammography using procedure code G0236 as an add-on code. The ACR also appreciates CMS’ consideration to approve uses of CAD as an add-on to digital mammography in the future.

Again, the ACR appreciates the positive changes made to these areas. However, there remain several significant problems in this final rule related to radiology and radiation oncology. The following six issues are of major concern to ACR members. A detailed discussion regarding the issues surrounding these topics follows:

1) Practice Expense Reductions
2) SGR and the Conversion Factor
3) Mammography
4) Physician Self-Referral Prohibition List
5) Adequate Fund Distribution (Medicare A vs. B)
6) MRI Reimbursement
1) Practice Expense Reductions

The ACR has serious concerns regarding the extreme reductions in the majority of the radiology and radiation oncology PERVUs in both "in" and "out" of facility. Radiology and radiation oncology practices will see an average 10-12 percent decrease in payments due to practice expense decreases, coupled with the drop in the conversion factor. CMS states that "there might be slight changes to the RVUs for practice expenses as a result of updated information included in this final rule that affect all physician fee schedule services." However, there is an average 5 percent reduction in the PERVUs for the radiology and radiation oncology codes that are currently in the zero work pool, as well as an 8 percent reduction for the majority of the radiology and radiation oncology procedures that are not in the zero work pool (the professional component). The ACR considers these reductions to be significant, disproportionate, and, if implemented, devastating in their effect on radiology and radiation oncology practices.

These practice expense reductions, in conjunction with the reductions to the conversion factor, may drastically reduce access for Medicare beneficiaries to receive services in free-standing imaging centers. The ACR has received numerous phone calls and e-mails reporting the reductions in the 2002 local MFS and the devastating effect it will have on radiologists, radiation oncologists, nuclear medicine physicians and medical physicists. The ACR requests that CMS delay implementation of the revised PERVUs for radiology and radiation oncology services, and freeze values at the 2001 MFS rate.

CMS did not adequately explain these changes in the text of the rule or provide the required comment period to address these reductions. The ACR appreciates CMS'' most recent explanation by conference call and e-mail of how these changes were made but does not feel that this satisfies the requirement for public comment. The ACR looks forward to working with CMS on this issue in the first quarter of the coming year. Also, the ACR requests that, in the future, when CMS foresees such significant reductions, it should publish notification of them in the text of the proposed and final rules in impact tables detailing the changes.

Zero Work Pool

The ACR continues to support CMS'' position to maintain the separate practice expense pool for services with no physician work until there is an appropriate methodology established to eliminate this pool. CMS states, "We plan to eliminate this separate pool for services with no physician work only when we have determined what revisions to our methodology are required so that we can value these services appropriately outside of the zero work pool." The ACR strongly requests input on any changes in methodology, since radiology and radiation oncology codes with zero work values represent a major portion of this pool. The ACR would like feedback from CMS on the most effective way to get involved in this process.

2) SGR and the Conversion Factor

The ACR continues to argue that the conversion factor used to calculate physician payments has been inappropriately reduced for 2002. The ACR remains concerned with the formula used to update Medicare payments annually for physicians'' services and the impact it has on quality patient care. Although the ACR recognizes that CMS does not write the formula used to calculate the SGR, the ACR suggests that CMS address problems surrounding the MEI and SGR calculations, such as physician productivity and unfunded mandates that increase both physician work and practice costs.

The "productivity adjustment" is a key component of the MEI, and the ACR believes that the productivity adjustment in the MEI overstates productivity gains in the physician services industry. The ACR believes that productivity growth in physician practices is likely to be low in comparison to other service industries due to the massive and growing regulatory burden that physicians face. Physician compliance regarding documentation requirements (such as the ordering of diagnostic tests) places demands on physician and staff time and reduces physician productivity. As such, the ACR would argue that the regulatory burden has caused physician productivity to decrease—not increase—over the past several years, thus making the conversion factor reduction inappropriate.
The ACR is also concerned about the lack of adequate reimbursement to cover the increasing wage rates, demonstrated by the BLS. The reduction in the conversion factor, and thus, the decrease in total practice expense reimbursement, coupled with the rising wage rates, only exacerbates the problem of covering the direct costs of providing patient care. The ACR urges CMS to address the issue of adequate aggregate reimbursement to cover rising wage rates.

3) Mammography

Screening
The ACR is very concerned about the 2002 payment rates for screening mammography. Specifically, in the August 2 proposed rule, CMS published a screening mammography reimbursement rate of $88.38, establishing RVUs for physician work, practice expense and malpractice values equivalent to a unilateral diagnostic mammogram. The ACR supported this proposed rate, which was in line with what the ACR’s screening mammography cost survey shows as the dollar amount needed to cover costs for this procedure in the office setting. However, CMS published a screening mammography reimbursement rate in this rule of $80.73. This new reimbursement level falls short of what is needed for radiology practices to be able to provide this service. As such, the ACR continues to have serious concerns regarding patient access to mammography services as a result of these new rates.

Also, the ACR is disappointed that CMS stated that "we will finalize our proposed relative values, because we believe they are an accurate reflection of the cost associated with the provision of these services," and subsequently changed the RVUs associated with these CPT codes. ACR understands that a portion of the reductions in the PERVUs can be attributed to a technical error involving screening mammography and CAD. The ACR requests that adjustments be made, that the CMDs be notified of the correct payment rates and that these rates be effective January 1, 2002, with retroactive payment, if necessary.

Malpractice
The ACR supports CMS' decision to examine the issues of malpractice as they relate to screening mammography. The ACR continues to believe that the screening mammography malpractice RVU apportionment should be reversed for the professional and technical components (i.e., 76092-26 MP RVUs should equal 0.06 and 76092-TC MP RVUs should equal 0.03) as the malpractice expense and risk is primarily with the interpreter of the screening mammogram, not the facility producing the technical component. The ACR looks forward to working with CMS on this issue.

New Technology
CMS states in the final rule, "We are establishing several new codes and fee schedule amounts for screening and diagnostic mammography services that involve use of a new technology. We believe this will help ensure that all Medicare beneficiaries have access to the benefits of mammography, including recent advances that further enhance the clinical capability of this vital health service for women."
However, the ACR believes that patient access to mammography services is not addressed through the establishment of RVUs for new digital technology, as this new digital technology is only available at a very small percentage of mammography facilities. The ACR continues to believe that the key way to address patient access problems is to establish adequate reimbursement levels for conventional film-screen mammography procedures used by the vast majority of facilities performing screening mammography. According to the statistics published on the FDA Web site, the number of "certified mammography facilities" has decreased approximately four percent over the past nine months, from 9873 to 9491 sites.

Diagnosisal Mammography
The ACR appreciates CMS' increase in the physician work RVUs for both the unilateral and bilateral diagnostic mammography CPT codes, as a result of the Five Year Review. However, the ACR is disappointed that, as a result of CMS' panel review of ACR's original RUC proposal, the median physician work values were not accepted.

4) Physician Self-Referral Prohibition List
The ACR continues to urge CMS to include nuclear medicine on the "designated health services" list of CPT/HCPCS codes. As stated in a July 31, 2001 letter from ACR to CMS specifically on this issue, the ACR stated concerns that CMS" decision to exclude nuclear medicine could cause greater risk of program, if not patient, abuse—the very conditions that the Stark II statute and regulations are intended to halt. The ACR requests that CMS make the recommended changes to the list, Addendum E in the MFS, with an effective date of January 1, 2002.

5) Adequate Fund Distribution (Medicare A vs. B)

The ACR has concerns that as services are being shifted from inpatient to outpatient settings, the proportionate funding for these services is not being shifted from the Medicare Part A pool into the Medicare Part B pool to cover the costs. For example, CMS states in the final rule that "physical and occupational therapy services previously paid on the basis of a cost report through the Medicare fiscal intermediaries (i.e., hospital services) are more likely to be billed by therapists in independent practice because these services are no longer being paid on a cost basis." The ACR urges CMS to ensure that adequate funding is transferred from the Medicare Part A pool to the Medicare Part B pool to cover changes like this in billing practices.

6) MRI Reimbursement

The ACR appreciates CMS" decision to revise physician work values for several of the new "body" MR codes. However, the ACR, with RUC endorsement, believes that these numerous MR procedures performed "with contrast" or "without followed by with contrast" represent new work and thus should not be subject to the "within family work neutrality adjustments." Applying this adjustment creates rank order anomalies between these MRI codes and existing head and spine MRI codes. The ACR continues to support the original RUC recommended values. Therefore, the ACR requests that these values be considered interim for CY 2002 and that CMS reconsider the ACR"s and the RUC"s original recommendations that these codes represent new work.

Other Issues

In addition to the six major issues detailed above, the ACR has concerns related to the following six issues.

- Issues related to clinical labor, such as adequate reimbursement for clinical wages clarification regarding the vascular technologist"s role, merging of the X-ray technician and radiation technologist into one clinical wage rate and the blending of RNs and sonographers into one category
- The scope of consideration for the refinement panels
- Concerns related to specific radiology and radiation oncology procedures, such as RFA and IMRT
- Problems with the methodology for establishing malpractice RVUs
- The review cycle for "high tech" equipment and supplies
- Support for the use of "top-down" methodology for computing resource-based practice expense RVUs

Clinical Wage Rates

The ACR supports CMS" decision to use the most appropriate salary survey data to make revisions to the vascular technologists clinical wage rate. However, the ACR seeks clarification of the phrase "a vascular technologist functions as a direct and largely independent health care practitioner," as vascular ultrasound exams still require physician supervision.

The ACR does not support CMS" decision to merge the "X-ray technician" and "radiation technologist" staff types under the title of "radiologic technologist." The education and scope of practice are drastically different for these two types of clinicians. X-ray technicians are paid at a lower wage than radiation technologists. Merging these two staff types will reduce the radiation technologists" wage rate. Therefore, the ACR would support two separate categories for these clinical staff types.
The ACR continues to strongly oppose the CMS decision to “blend” the clinical staff types of RNs and sonographers. As stated in the ACR’s NPRM comments, RNs and sonographers undergo entirely different education and training programs and therefore do not perform the same tasks. The ACR acknowledges that the per-minute practice expense may be equal, but disagrees with CMS’ statement in the final rule that “The CPEP clinical staff inputs also include blends of staff types that are used for those services when more than one type of clinical staff may be used in the performance of the service.” [page 55261 42 CFR Part 405]. The ACR would like to stress that each group is trained to provide different services and that these staff types are not interchangeable. The ACR requests that the RN/Sonographer category be broken into two separate categories to represent their own staff type and functions, maintaining the current cost input for each.

**Refinement Panels**

The ACR strongly objects to CMS’ statement: "Our decision to convene a multispecialty refinement panel of physicians and to apply the statistical tests referred to above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties." The ACR does not believe that evaluating the "redistributive effects" of recommended RVUs is within the scope of refinement panels. The objective of the refinement panel should be to evaluate the recommendations of the specialty or other commenter to modify proposed RVUs, based on clinical evidence and survey data, independent of "redistributive effects". The ACR is concerned that high-volume services might not be fairly evaluated if "redistributive effects" are used as an evaluation criterion. The ACR strongly recommends that CMS revise its instructions to the refinement panel to review recommendations based solely on survey data and appropriate placement of a procedure in the Resource-Based Relative Value Scale (RBRVS).

**Radiofrequency Ablation (RFA)**

The ACR does not support the RVUs established for CPT code 47382 percutaneous radiofrequency or CPT code 76490 ultrasound guidance for tissue ablation. The ACR presented survey data at the April 2001 RUC meeting and plans to resubmit data to the RUC this year; however in the interim, the ACR would argue that the newly established RVUs for these two CPT codes are not adequate. Due to the nature of these codes (i.e., real-time monitoring of coagulations of the ablated lesions) the RVUs established do not adequately reflect the amount of physician work involved in these procedures. The ACR would recommend 17.50 RVUs for CPT code 47382 and 4.00 RVUs for CPT code 76490. The ACR requests that CMS revise their decision regarding the valuation of those two CPT codes and make the recommended changes. The ACR recognizes that these values are interim and can be revised based on the RUC recommendations but has concerns about Medicare beneficiary access to these important procedures.

In addition, the ACR does not support CMS’ decision to crosswalk the PERVUs of CPT code 47382 to CPT code 47525, as the resources for these procedures are drastically different. The ACR believes that the PERVUs established for CPT code 47525 would not reflect the costs associated with the RF equipment, nor the clinical time needed to complete this procedure.

**IMRT**

The ACR appreciates CMS’ decision to accept the RUC-recommended RVUs for the two new IMRT codes. However, the ACR does not support CMS’ decision to reduce the radiation therapist time from 123 minutes to 60 minutes under CPT code 77418. The 60 minutes is only reflective of the time of the delivery session, but two technologists would typically be involved in the delivery procedure. Therefore, the ACR urges CMS to revise their decision to reflect 123 minutes of radiation therapists' time for CPT code 77418.

The ACR would also like to comment that the physician work for the IMRT codes should only have those services bundled that are outlined on the CPT application and that all other services should be coded and paid separately. IMRT, like all other radiation oncology procedures, is often utilized with other components to the course of treatment (including consultations, treatment devices, medical physics consults, etc.) that were not included in work and practice expense valuations by the RUC. All Medicare patients should be allowed the same level of quality patient care regardless of the treatment course
selected for their disease state. The ACR would be happy to further explain the complex elements and coding of this treatment for Medicare patients to CMS if needed.

**Malpractice RVUs**
The ACR continues to have concerns about the methodology in place for the assignment of malpractice RVUs. For example, the malpractice RVUs have been established at an equal rate for glaucoma screening and medical nutrition therapy (performed by a non-physician) with a chest X-ray (interpreted by a physician). The chest X-ray is the second most common exam producing a claim of malpractice for radiology. The ACR believes that this example demonstrates the deficiency in the malpractice methodology, which currently assigns the majority of the radiology malpractice RVUs to the technical portion of the code rather than to the professional component where the majority of the malpractice risk and cost exists.

**Review Cycle for "High-tech" Equipment and Supplies**
The ACR supports the routine review of aggregate practice expenses. However, a review cycle of five years may not appropriately capture the "ever changing" costs associated with high-tech equipment and supplies. Therefore, the ACR would recommend that the review cycle be revised to reflect a maximum three-year cycle, with a potential for specialties to ask for interim changes.

**Support for "Top-down" Methodology**
The ACR continues to support the use of the "top-down" methodology for computing resource-based practice expense RVUs. The ACR is concerned with the CMS statement, "Since there are no other data on aggregate multispecialty practice costs that are better than the SMS, our only alternative would be to eliminate the SMS data from the methodology and rely solely on estimates of practice expense inputs for individual codes." The ACR and other medical specialties have participated in good faith at the PEAC with the understanding that the data supplied would be applied to practice expense pools defined by a "top-down" methodology and not to be reapplied later with what seems would be the "bottom-up" method.

Also, the ACR is very concerned with the AMA"s most recent mini-SMS surveys and, more specifically, the one created for radiology. The ACR was not given input on this mini-survey and may have concerns about the data collected with such a survey if the questions are not reflective of true radiology and radiation oncology practice costs. The ACR reserves the right to comment on this data in the future as it becomes available to CMS.

**Ensuring Medicare Beneficiary Access**
The ACR emphasizes that reductions in the conversion factor, professional and technical practice expense values and, more specifically, that screening mammography problems must be resolved in order for radiologists, radiation oncologists, nuclear medicine physicians and medical physicists to continue to provide adequate care to Medicare beneficiaries. The ACR looks forward to discussing these issues further with CMS in the near future and appreciates this opportunity to comment. If you have any further questions or comments on these or any other issues, please do not hesitate to give me a call at (800) 227-5463, ext. 4335.

Sincerely,

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