October 1, 2001

Thomas A. Scully
Administrator, Center for Medicare and Medicaid Services
Department of Health and Human Services
Room C5-14-03
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar-Year 2002; Proposed Rule

Dear Mr. Scully:

The American College of Radiology (ACR) appreciates the opportunity to comment on the August 2, 2001 Notice of Proposed Rule Making. The ACR has reviewed the rule and has several comments and concerns on issues that affect radiology and radiation oncology.

Mammography

Screening
The ACR appreciates CMS's work on the issues surrounding mammography. While we believe that CMS's comparison of a screening mammogram to a unilateral diagnostic mammogram is an appropriate comparison, as CMS is aware, the ACR will continue to work with Congress to assure that screening mammography is reimbursed at an appropriate level. The ACR still believes it is best that screening mammography reimbursement reach an appropriate level prior to inclusion in the Medicare Fee Schedule in order to ensure that aggregate funding is transferred to the Fee Schedule to cover this critical procedure. There are other concerns surrounding mammography that at present the ACR feels may best be addressed through a legislative effort. These issues include physician reimbursement, practice expenses associated with compliance with the Mammography Quality Standards Act (MQSA), and workforce problems. Unfortunately, many of these and other expenses cannot be accounted for under the current Medicare RVU payment methodology.

The ACR recognizes that CMS is currently under Congressional mandate to establish values for screening mammography, and appreciates the significant effort that CMS has put forth to comply with that mandate. Thus, despite our reservations stated above, we would like to submit the following comments regarding the proposal.

Physician Work
The ACR supports the CMS proposal to establish physician RVUs for screening mammography equal to unilateral diagnostic mammography.

Practice Expense
The ACR believes that due to federally mandated MQSA requirements intrinsic to mammography (both screening and diagnostic), it is difficult using current methodology to account for all practices expenses. Thus, the methodology needs to be revised. That said, using current methodology, the ACR supports the proposal that the practice expense RVUs associated with screening mammography are best estimated by comparison to those associated with unilateral diagnostic mammography as proposed.

Malpractice
The screening mammography malpractice RVUs should be higher than the unilateral diagnostic mammography value of 0.03, since most mammography malpractice claims arise from allegations of cancers not detected or inappropriate follow up of screening mammograms, not diagnostic studies. In
addition, the screening mammography malpractice RVU apportionment should be reversed for the professional and technical components (ie. 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.

Direct Digital
The ACR appreciates that CMS has been instructed by Congress to determine a method to reimburse for direct digital mammography services. There is a large multicenter trial underway comparing film-screen and full field digital mammography, including comparison of the physician work and practice expenses of this new technology. This trial will best determine appropriate relative valuation but results will not be available for some time. Due to the ability of the radiologist to manipulate the digital mammogram image, the ACR feels there may be more work involved in the interpretation of a digital mammogram than is currently required for an analog image. The ACR believes the rationale that the physician work RVUs should be equal for direct digital mammography and a film-screen mammographic exam will have to be reconsidered as this data becomes available.

CAD (Computer Aided Detection for Mammography)
The ACR agrees with CMS’ proposal to set the physician work value for CAD at a .06 RVUs. The ACR believes that there clearly is additional physician work involved in the utilization of CAD. Therefore, the ACR has collected data through the RUC survey process and will make recommendations to the RUC on the physician work to support this value. In addition, the ACR feels that this new technology represents new physician work.

The ACR requests that CMS expand CAD coverage for Medicare beneficiaries to include diagnostic mammography. Note, on May 29, 2001, the Food and Drug Administration (FDA) approved CAD for diagnostic mammography. The ACR recommends that CMS modify the current “G” code for screening to include diagnostic mammography or create a separate code reflecting the same additional work and practice expense.

Practice Expense
Adjustment of Wage Rates
The ACR strongly opposes the CMS proposal to “blend” the clinical staff types of RNs and sonographers. RNs and sonographers undergo entirely different education and training programs and therefore do not perform the same tasks. Each group is trained to provide different services that are not interchangeable. The ACR does not disagree that the per minute practice expense may be equal, but disagrees with blending these as sonography services are not an example of “services where more than one type of clinical staff may be used in the performance of the service” (pg. 40381).

The ACR strongly opposes the decrease in wage rate for medical physicists. The American Association of Physicists in Medicine (AAPM) annually carries out a Professional Information Survey, which poses questions to its members regarding income. The AAPM is a national educational and professional organization of approximately 4,500 medical physicists. The main focus of the AAPM is to promote the application of physics to medicine and biology, encourage interest and training in medical physics and their related fields. Compared to the previous year, salary increases were up slightly, not down, as the CMS is proposing. The average primary salary for calendar year 2000 was $1.18 per minute. The ACR believes the data from the AAPM study is more relevant than the data in the American Academy of Health Physics and the American Board of Health Physics (AAHP) study referenced in this proposed rule. It is our understanding that the survey sample for the AAHP study does not include physicists in radiation. The ACR would be pleased to discuss this issue further with CMS.

The ACR also opposes combining dosimetrists and radiation therapists in the same group. These non-physician staff provide very different services for radiation oncology procedures and are paid at different pay scales. The ACR agrees with the proposed increase in per minute expense for radiation therapists but strongly disagrees with the proposal to combine dosimetrists which results in a decrease in the per minute proposed expense value for this important service.
A dosimetrist should be classified somewhere between a radiation therapist (tech) and a medical physicist, so there should be some separation in salary level. The dosimetrist, under the supervision of the physicist and based on the prescribed treatment needs determined by the radiation oncologist, helps develop the treatment plan including the isodose distribution. The radiation therapist is charged with properly positioning the patient daily for radiation treatment delivery according to the treatment plan, positioning blocks, shields, etc. and setting up the prescribed treatment parameters during treatment delivery, in which they are trained and licensed. The ACR would like to work with CMS to collect data regarding their salary values but expect that it will demonstrate an approximately 20% increase (i.e., approximately a per minute value of 0.600) since the 1993 data in parallel with the other statistics acquired from the BLS.

The ACR recognizes that there are different wage levels for technologists of the various imaging modalities. However, the growing level of complexity and technologic sophistication of the procedures requires a higher level of experience and training, and in many cases additional certification. In radiology practices and the healthcare market place, these are typically reflected differently in the wage levels. The ACR will attempt to gather this data during the final stage of the refinement process.

The ACR is concerned that the numbers provided in this proposed rule show a significant increase in wages for clinical staff, clearly indicating that practice expense for radiology and radiation oncology procedures is increasing. However, the practice expense per physician hour values for radiology have increased only minimally and for radiation oncology have decreased. This inconsistency indicates that though there will be an increase in the direct input practice expense for non-physician clinical labor related to the wage adjustments, this will have to be paid from a virtually static (for diagnostic radiology) or shrinking (for radiation oncology) practice expense pool. The only conclusion is that reimbursement for this additional labor cost will be at the expense of some other component of resource based practice expense within the specialties, yet we do not see any other component of practice expense actually shrinking.

Also, in response to the documented serious shortage of radiology and radiation oncology technologists in this country, the salaries for these employees are currently rising, not reflected in 1999 data. In addition, the use of time intensive new technology is increasing. Given these factors, the ACR is concerned that aggregate practice expense will not account for all of these additional factors in the relative values. Adjustments to a fixed budget that is not proportionately growing will provide RVUs that are not truly representative of the increasing prices of practice expense inputs.

The ACR has agreed in its previous comments on the proposed and final rules to the use of additional years of SMS data in calculating the physician hourly rate because of the low level of survey responses for radiology and radiation oncology. However, with the ending of the SMS survey process, CMS is now proposing to use this fixed dataset to determine practice expense pools through 2007. The ACR is concerned that, particularly for specialties with rapid changes in technology and resulting expensive clinical labor skill sets, the use of 1995 through 1999 data, will not accurately reflect the growth in wages, new technology supply and equipment costs and other input prices over the next 5 years, thus potentially stifling Medicare beneficiary access to improved healthcare options.

**Calculations of Zero Work Pool**

The ACR appreciates CMS’s position to maintain the status of the zero work pool until an appropriate methodology can be determined. The ACR would like to have input to the elements used in considerations regarding the zero work pool and the blending of the radiology zero work codes into the radiology practice expense pool. Radiology codes with zero work value represent a major portion of this pool.

**Deletion of Contrast Agents from the Practice Expense Inputs**

The ACR is concerned with the CMS proposal to delete the costs of the following contrast agents from their CPEP data – “hypaque, methylene blue, high density barium, polibar, teleepaque tablets, barium paste contrast, effervescent sparkles (fizzies) and renographin-60 iodinated contrast”. Previously,
contrast agents were defined as supplies and were included in the list of CPEP supplies for appropriate services. However, as a result of the BIPA legislation, contrast agents are now included in the definition of drugs and biologicals. Yet, there are no HCPCS codes established for these contrast agents in order to be reimbursed. The ACR would like confirmation that the contrast agents listed above will be reimbursed separately. The ACR believes that it was the intent of BIPA that separate and additional payments would be made for these agents in addition to the current reimbursement of the procedures.

**Medicare Physician Payment Update**

The ACR is concerned about the formula used to update Medicare payments annually for physicians’ services and the impact it has on quality patient care. The ACR suggests that CMS address problems surrounding the MEI and SGR calculations, such as physician productivity and unfunded mandates.

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. We believe that productivity growth in physician practices is likely to be low in comparison to other service industries due to the massive 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 physician productivity has decreased over the past several years, not increased.

In addition to the productivity adjustment, physicians have had to incur substantial financial burdens in order to comply with the fraud prevention programs, compliance programs, and quality improvement programs without any additional compensation. These programs require substantial financial resources and are forcing practice costs upward. Yet, the costs associated with these requirements are not reflected in the updates to Medicare payments for physicians’ services. In addition to these unfunded mandates, physicians also faced significant costs associated with year 2000 computer conversions, which are not reflected in the formula to calculate physician payments.

**Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists Performing Screening Sigmoidoscopies**

The ACR is concerned that CMS is proposing that the scope of practice for non-physician practitioners expand, that the level of quality of care to Medicare beneficiaries will not be maintained. The ACR believes that CMS should continue to require physician supervision and should monitor Medicare beneficiary outcomes to insure the safe and accurate performance of screening sigmoidoscopies.

**Performance Measurement and Emerging Technology Codes**

The ACR agrees with CMS’ proposal to provide payment for “emerging technologies” (referred to as Category III CPT codes), on a case-by-case basis. The ACR would hope that CMS would coordinate with the specialty societies to help determine which emerging technologies have demonstrated clinical effectiveness and utility and should receive payment.

**Payment Policy for CPT Modifier 62 (Co-Surgery)**

Due to the increase in minimally invasive and image guided surgical procedures, radiologists, and specifically interventional radiologists, are increasingly involved in surgical teams as co-surgeons or assistant surgeons. As such, if CMS intends to reevaluate these categories and modifiers, the ACR requests that it be involved in that reevaluation.

**Telehealth Services**

The ACR interprets the following statement [A patient’s medical information may include various combinations of video clips, still images, x-rays, magnetic resonance images, electrocardiograms …] to mean that information will only be provided to the distant site consulting practitioner in order for them to recommend or confirm a diagnosis or treatment plan, not for formal interpretation of imaging exams. If the scope of the telehealth services is expanded the ACR would like to discuss our standards on Teleradiology and Digital Image Data Management with CMS.
The ACR appreciates this opportunity to comment. If you have any further questions or comments on these or any other issues, please give me a call at (800) 227-5463 x4335.

Sincerely,

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