September 5, 2013

Marilyn B. Tavenner  
Administrator  
Centers for Medicare & Medicaid Services 
Department of Health and Human Services 
Attention: CMS–1600–P  
Mail Stop C4–26–05  
7500 Security Boulevard  
Baltimore, MD 21244–1850

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule

Dear Administrator Tavenner:

The American College of Radiology (ACR), representing more than 36,000 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 CY 2014 Medicare Physician Fee Schedule (MPFS) Proposed Rule.

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

- Impact of the Hospital Outpatient Prospective Payment System Proposed Rule on the Medicare Physician Fee Schedule
- Using Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Rates in Developing Practice Expense Relative Value Units
- Ultrasound Room Equipment Recommendations (General)
- Ultrasound Equipment Input Recommendations for Particular Services
- Direct Practice Expense Inputs for Stereotactic Radiosurgery Services
- Misvalued Codes
- Revising the Medicare Economic Index
- Utilization Rate
- Multiple Procedure Payment Reduction
- Quality Provisions
General Comment

Policy makers have raised concerns about a “significant growth in spending on imaging” over the past several years as a justification for policy decisions which decrease payment for radiology services. The ACR would again like to point out data showing that total Medicare spending for imaging services has been on a steady decline. In April of this year, the American Medical Association (AMA) released an analysis of the estimated change in sustainable growth rate (SGR) spending from 2011 to 2012. The AMA used data from the 2011 and 2012 Medicare Physician/Supplier Procedure Summary (PSPS) files and determined that spending for imaging services declined by 6 percent ($659 million). Growth in imaging peaked in 2006 and then plateaued and declined afterwards. This was seven years ago. The ACR urges CMS to acknowledge this downturn and to advise its staff and contractors not to use the outdated language that points to a significant growth in spending when Medicare data shows the opposite trend.

Impact of the Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule on the Medicare Physician Fee Schedule for Radiology Services

The ACR is very concerned about the apparent lack of recognition of the complete impact of the OPPS proposed rule on the MPFS for imaging services. As you know, the Deficit Reduction Act of 2005 (DRA) caps payments for the technical component (TC) of certain imaging services in the office setting at the lesser of the MPFS or OPPS rates. Proposals in the 2014 OPPS rule such as using separate cost centers for computed tomography (CT) and magnetic resonance (MR) significantly reduce OPPS payments which, therefore, impacts the MPFS payment rates for these same services due to the DRA cap. ACR staff attended the July 18th meeting with CMS staff hosted by the AMA and asked if the impact of the OPPS proposal on the MPFS was considered. The response by CMS was that the Agency did not believe there was a significant impact. CMS estimated an overall impact to radiology services of -1 percent, however, specific impacts at the code level are much greater. The ACR, working with The Moran Company, conducted a detailed analysis of the practical impact of this policy as well as other various proposals in the OPPS and MPFS rules. The analysis demonstrates huge cuts and inaccurate Medicare reimbursements for certain CT and MR services in both the hospital and non-hospital settings, jeopardizing patient access to these services.
For example, below is a table showing technical component reimbursement rates for ten Current Procedural Terminology (CPT®) codes that are not capped by the DRA in 2013, but will face significant reductions in 2014 should the proposals within the OPPS rule be finalized.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2013 NF* Pay (DRA cap does not apply)</th>
<th>2014 NF Pay after DRA cap</th>
<th>Change in NF Pay 2013-2014</th>
<th>% Change 2013-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>70490</td>
<td>Ct soft tissue neck w/o dye</td>
<td>$163.65</td>
<td>$113.21</td>
<td>$-50.44</td>
<td>-30.8%</td>
</tr>
<tr>
<td>71250</td>
<td>Ct thorax w/o dye</td>
<td>$163.99</td>
<td>$113.21</td>
<td>$-50.78</td>
<td>-31.0%</td>
</tr>
<tr>
<td>72125</td>
<td>Ct neck spine w/o dye</td>
<td>$166.37</td>
<td>$113.21</td>
<td>$-53.16</td>
<td>-32.0%</td>
</tr>
<tr>
<td>72128</td>
<td>Ct chest spine w/o dye</td>
<td>$165.35</td>
<td>$113.21</td>
<td>$-52.14</td>
<td>-31.5%</td>
</tr>
<tr>
<td>72131</td>
<td>Ct lumbar spine w/o dye</td>
<td>$164.67</td>
<td>$113.21</td>
<td>$-51.46</td>
<td>-31.3%</td>
</tr>
<tr>
<td>72191</td>
<td>Ct angiograph pelv w/o&amp;w/dye</td>
<td>$319.48</td>
<td>$279.52</td>
<td>$-39.96</td>
<td>-12.5%</td>
</tr>
<tr>
<td>73200</td>
<td>Ct upper extremity w/o dye</td>
<td>$163.31</td>
<td>$113.21</td>
<td>$-50.10</td>
<td>-30.7%</td>
</tr>
<tr>
<td>73700</td>
<td>Ct lower extremity w/o dye</td>
<td>$163.99</td>
<td>$113.21</td>
<td>$-50.78</td>
<td>-31.0%</td>
</tr>
<tr>
<td>74175</td>
<td>Ct angio abdom w&amp;o &amp; w/dye</td>
<td>$320.16</td>
<td>$279.52</td>
<td>$-40.64</td>
<td>-12.7%</td>
</tr>
<tr>
<td>78647</td>
<td>Cerebrospinal fluid scan</td>
<td>$334.79</td>
<td>$178.53</td>
<td>$-156.26</td>
<td>-46.7%</td>
</tr>
</tbody>
</table>

*NF = Non-Facility

Payment for many imaging codes are facing decreases in 2014 due to many factors including the statutory change in the equipment utilization rate, interest rate changes, and changes in practice expense (PE) inputs. For example, in addition to the 10 codes in the above table, CPT code 75571 (Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium) is facing a 62.75 percent decrease and 73718 (Magnetic resonance imaging lower extremity, without contrast material) is facing a 17.6 percent decrease.

The ACR and other stakeholder organizations participated in a meeting with Deputy Director Elizabeth Richter to relay our specific concerns about the CT and MR cost center proposal for the Inpatient Prospective Payment System (IPPS), which has since been finalized, and those concerns are reiterated in our comment letter on the OPPS proposed rule.

The ripple effect of OPPS payment rates on physician office services heightens the importance of ensuring that any changes made to the OPPS methodology are fully
justified. This is not simply a matter of ensuring that hospitals will be appropriately reimbursed.

CT and MR services have endured 12 cuts since 2006, the majority of which have been applied to the TC. In addition, another impending 10 percent TC cut will take place with the implementation of the 90 percent equipment utilization rate as mandated by the American Taxpayer Relief Act of 2012 (ATRA) for CY 2014. Additional payment reductions would make these studies non-viable in the office setting since physician offices would be unable to cover the costs necessary to provide these services, under even the most cost-efficient scenario.

In 2011, the ACR recommended that CMS delay establishing new standard cost centers for CT and MR until the causes of the payment distortions associated with the Research Triangle Institute (RTI) methodology are understood and remedied. CMS nonetheless chose to establish these separate cost centers. Now that we have actual cost-to-charge ratios (CCRs) for each of the radiology cost centers, we believe these values raise many questions about the appropriateness of applying these new CCRs. We recommend for 2014 and future years that CMS continue to use only the single diagnostic radiology CCR and not use the proposed CT and MR CCRs for determining ambulatory payment classification (APC) weights.

The ACR is very concerned about the cumulative impact of proposed payment policies in the OPPS and MPFS proposed rules and CMS’ apparent lack of recognition of the impact of the OPPS proposals on the MPFS given the DRA payment caps. We urge CMS staff engaged in the MPFS rule making process to share our concerns and observations with their CMS colleagues engaged in the OPPS rule making process.

**Using Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Rates in Developing Practice Expense Relative Value Units**

CMS is proposing a change in the practice expense methodology beginning in CY 2014 and subsequent years in order to “improve the accuracy of PFS nonfacility payment rates”. The ACR believes that the proposal to use the current year OPPS or ambulatory surgical center (ASC) rates as a point of comparison in establishing PE relative value units (RVUs) for services under the PFS is inappropriate. Costs for the CPT codes included in a given APC may vary considerably, even more than two times in some cases (where the 2 times rule is waived), and thus using APC rates can disadvantage physician offices. Unlike hospitals and ASCs, physician offices may not have the volume of services needed to offset underpayments for certain CPT codes. Hospital payment methodologies typically assume that any underpayments for one service will be offset by overpayments for another service so that average payments are fair. This same assumption does not apply to the physician office. Hospitals are also
eligible to receive outlier payments under Medicare’s OPPS; no comparable protections are afforded in the physician office setting.

The proposed rule provided too little detail about exactly what CMS was proposing and it took considerable time during the comment period to obtain the information needed to understand and replicate the CMS methodology, especially with respect to the 5 percent “low volume” threshold and whether payment for a specific code was being capped at the ASC or OPPS levels. The proposed rule itself did not even include a list of affected codes but instead directed readers to Addendum B, which is simply a complete list of all codes paid under the Medicare physician fee schedule. It still remains unclear how the “Codes with Low Volume in the OPPS or ASC” exemption is applied as many impacted codes subject to the ASC cap fall below the 5 percent threshold in the ASC setting. In fact, over half of the services on the list are capped at the ASC rate, yet only 9 of those codes would meet the 5 percent threshold and not one of those 9 codes was billed more than 600 times in 2012.

CMS states that higher reimbursement within the hospital setting is appropriate due to higher overhead costs and feels that any service that maintains a higher reimbursement rate in the office setting is not a result of appropriate payment differentials, but rather “anomalies” in the data used in the MPFS methodology. CMS appears to ignore the bottom-up methodology used in the AMA’s Relative Value Scale Update Committee (RUC) process in the practice expense methodology that was previously championed by CMS. The 2006 MPFS proposed rule states, “The PEAC/PERC/RUC has completed the refinement of the original CPEP data and we believe that the refined PE inputs now, in general, accurately capture the relative direct costs of performing PFS services.” (Federal Register Vol. 70, No. 151, pg. 45776). Additionally, under current policy, physician office rates are used in some cases to cap ASC payments. Now CMS proposes to cap some physician office services at ASC rates. This smacks of an arbitrary search for the lowest payment produced under any of the CMS payment systems and then applying it to other settings, whether that is appropriate or not.

The proposed policy change is particularly damaging to CPT codes which have high direct practice costs. For example, 82 percent of the codes on the list have direct practice expense costs which exceed the proposed payment cap amount, making them unsustainable in the office setting. This payment anomaly affects two families of radiology codes: (1) percutaneous kyphoplasty and vertebroplasty and (2) lower extremity revascularization. There are also a number of individual codes for which a single direct expense input exceeds the payment cap amount. This is also the case for the family of kyphoplasty codes where the kyphoplasty supply kit itself costs more than the total cap payment amount. For example, CPT code 22524 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral
cannulation (eg, kyphoplasty); lumbar) would suffer a 42.9 percent reduction due to the ASC cap despite the fact that it is only performed 3.9 percent of the time in the ASC setting.

The family of gastrointestinal tube procedures suffers similarly dramatic reductions. CPT code 43760 (Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance) suffers a 68.2 percent reduction specific to the ASC cap but it is only performed in the ASC setting 2.27 percent of the time.

Below is an illustration of some of the large impacts on global payments for radiology and radiation oncology services. The final column in the table indicates the approximate percentage of the total payment reduction that is due to the proposed cap.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2013 NF Pay</th>
<th>2014 NF Pay</th>
<th>Change in NF Pay 2013-2014</th>
<th>Total % Change 2013-2014</th>
<th>% Change due to proposed cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>43760</td>
<td>Change gastrostomy tube</td>
<td>$531.78</td>
<td>$152.65</td>
<td>$-379.13</td>
<td>-71.3%</td>
<td>-68.2%</td>
</tr>
<tr>
<td>77615</td>
<td>Hyperthermia treatment</td>
<td>$1,018.99</td>
<td>$522.14</td>
<td>$-496.85</td>
<td>-48.8%</td>
<td>-45.9%</td>
</tr>
<tr>
<td>77301</td>
<td>Radiotherapy dose plan imrt</td>
<td>$1,990.35</td>
<td>$1,453.36</td>
<td>$-536.98</td>
<td>-27.0%</td>
<td>-23.6%</td>
</tr>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>$531.44</td>
<td>$385.90</td>
<td>$-145.54</td>
<td>-27.4%</td>
<td>-23.7%</td>
</tr>
<tr>
<td>77404</td>
<td>Radiation treatment delivery</td>
<td>$142.22</td>
<td>$100.58</td>
<td>$-41.64</td>
<td>-29.3%</td>
<td>-24.5%</td>
</tr>
</tbody>
</table>

CMS also reasons that voluntary information on certain direct costs, such as capital equipment, has been difficult to obtain thereby justifying the proposal. While we recognize that some invoices related to new technology by nature may only be found at select centers, the ACR remains willing and able to work with CMS to locate this information upon request.

CMS also raises a concern that the data used in the current practice expense methodology can often be outdated and believes that as new technology is diffused into clinical practice, there is a resulting decrease in the cost of certain expensive items. The ACR disagrees and points to examples of new technologies that result in increased costs. In general, new imaging technologies do not remain static. Rather, they continue to improve over time with new innovations that require additional expenses, for example multi-
detector CT scanners or time of flight positron emission tomography (PET) scanners that are not reflected in the original expense calculations. These innovations often offset the decreasing “diffusion of technology” expenses CMS assumes. Would CMS be willing to accept new invoices reflecting the costs of new and improved equipment innovation for existing CPT codes?

A number of the affected codes have recently been reviewed or re-reviewed by the RUC and their resource inputs were examined in considerable detail and adjusted, where necessary. It is unreasonable for CMS to argue that hospital charge data and cost-to-charge ratio calculations across cost centers that include a wide array of items and services is more accurate than a code-specific determination of inputs by physicians who actually furnish the service. For example, CPT codes 22523 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic), 22524 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar) and 22525 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body) were just reviewed by the RUC in September of 2011. If CMS chooses to finalize the proposal, the ACR recommends that all codes reviewed by the RUC and its PE Subcommittee within the last 3 years be exempt from the proposed cap since their direct inputs would be expected to better represent clinical reality.

The ACR is also concerned about the use of disparate years to determine payment rates as CMS proposes to compare the 2014 NF PE RVUs to the 2013 OPPS/ASC payment rates. This ignores increases which will occur in the OPPS and ASC payment rates between 2013 and 2014 such as conversion factor increases and APC weight changes. For example, all of the radiation oncology codes impacted by the proposed cap have proposed increases for 2014. CPT codes 77412-77416 for radiation treatment delivery would increase by 23.9 percent if the 2014 rates were used.

The ACR would also like to point out that some of the impacted codes are subject to the surgical multiple procedure payment reductions (MPPR). Similar to what has been established with the DRA imposed OPPS cap, if CMS moves forward with this policy, the 50 percent MPPR should first be applied to the MPFS amount and then compared to the OPPS/ASC amount to determine final payment. The 50 percent reduction should not apply to the already lower OPPS/ASC rate.
Ultrasound Room Equipment Recommendations (General)

CMS is seeking comment on the items included in the ultrasound room packages as compared to items included in other equipment rooms. The RUC has created a work group to examine ultrasound room equipment pricing and the ACR is engaged in this process.

The proposed rule indicates that CMS believes that not all of the equipment items listed in the ultrasound room packages are used for all ultrasound services. CMS indicates that “Ordinarily under the PFS, direct PE input packages for “room” include only equipment items that are typically used in furnishing every service in that room”. This statement conflicts with precedent established in prior year’s rule making. Current practice expense methodology is predicated on a ‘typical service’ concept which includes equipment used for the typical service. It is recognized that a room will be used for other services whose expenses are not recognized in the expense methodology. The nuance of changing from ‘typical service’ to ‘typically used’ for ‘every service’ as CMS proposes for ultrasound creates an untenable variation in the established expense methodology. The ACR recommends that ‘typical service’ remain the standard and if an item is used for a typical service performed in that room it should remain.

The RUC Ultrasound Equipment Workgroup thoroughly reviewed the ultrasound room inputs and determined that to provide a range of typical services in the general ultrasound room, the recommended items are needed. Specifically, although all five transducers may not be used for every service furnished in the room, all five transducers need to be available for the spectrum of typical services furnished in the room. While the ACR agrees that any given study may not use all of the transducers, this varies on a patient-by-patient basis. This determination is influenced by clinical presentation, body habitus and the like. Often, the technologist and physician do not know beforehand what varied supplies may be necessary. Accordingly, to provide ultrasound services to any facility or community, all of the supplies are necessary. It would be inappropriate to provide ultrasound services otherwise and these costs are absorbed by physician practices.

Although the equipment rooms are packages, including a number of equipment items, they remain direct PE equipment inputs and as such the PE Subcommittee of the RUC follows the same guidelines as established by CMS to attribute equipment time. These guidelines state that equipment time is comprised of any time that a labor category is using the piece of equipment, plus any additional time the piece of equipment is not available for use with another patient due to its use during the procedure in question.

Therefore, the ACR believes that equipment package rooms should include all of the items included in an actual room which cannot be used for another patient since the determination of which specific items will be used is made at the time of service.
In addition to the concerns regarding the contents of the ultrasound room packages, CMS also expressed a concern about the pricing information submitted through the AMA RUC. The proposed rule points to “certain publicly available information”, specifically, an article from the Milwaukee Journal Sentinel citing vendor-provided equipment pricing information. The ACR cautions against using the lay press to validate or invalidate physician expenses as opposed to paid invoices. That said, the specific article cited within the rule quotes $200,000 for the “Logiq E9” which is within 10 percent of the $220,000 price in the RUC PE database. Such 10 percent variability could easily occur across the market and care should be taken in pricing to avoid using values which may be unattainable for smaller practices such as in rural settings where coverage is critical. It is also unclear from the article what the pricing information includes. Specifically, does this price include transducers, software, Doppler/Duplex capability, DICOM interface, monitor/laptop for viewing, transport stand, printer for hard copy, etc? We would also like to point out that the lowest price quoted in the article, $7,900 for a hand-held ultrasound is actually the price of GE’s “pocket” ultrasound, which is different than a standard “portable” ultrasound unit.

Again, the ACR cautions against using such broad public information as a basis of comparison for the pricing information submitted through the RUC process. The ACR is working to obtain paid invoices for the general ultrasound room and the portable ultrasound unit and is willing to assist in gathering whatever other information CMS requires to determine accurate pricing information.

**Ultrasound Equipment Input Recommendations for Particular Services**

CMS states that there is a concern with the accuracy of the procedure time assumption used in establishing the direct PE inputs for CPT code 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) and proposes that the procedure time be reduced from 45 to 10 minutes, based on analysis of thirty needle placement procedures most frequently reported with this code. The use of intra-service time of the accompanying procedure codes as the basis for the intra-service time for CPT code 76942 ignores the important fact that imaging guidance includes activities beyond the base surgical activity. Thus, there is no reason to think these times would be the same or that the total time for the surgical procedure would equal surgical plus imaging. For example, imaging guidance requires preparing the machine and patient, capturing and storing images and the like. The equipment time should be apportioned between the surgical and guidance codes, a longstanding convention. In fact, even staff activities of the technologist are allocated between the procedure code and the supervision and interpretation code.
The ACR would also like to point out that CPT code 76942 is scheduled to be reviewed by the RUC in April 2014 and a CPT coding proposal has been prepared for the October 2013 CPT Editorial Panel meeting to bundle the joint aspiration and imaging guidance codes for 2015. In view of the upcoming survey of this code in April and the development of new PE inputs at that time, we ask that CMS defer any changes in the procedure time for this code until the results of the new survey and the corresponding new PE inputs are available for consideration by CMS.

The ACR would also point out that the proposed changes in equipment type and time will cause significant reductions for 76942 (Ultrasound guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) and other codes in the ultrasound family.

The below table illustrates specific reductions in the technical component of ultrasound services due to the proposed direct input changes.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2013 NF Pay</th>
<th>2014 NF Pay</th>
<th>Change in NF Pay 2013-2014</th>
<th>Total % Change 2013-2014</th>
<th>% Change due equipment input</th>
</tr>
</thead>
<tbody>
<tr>
<td>76942</td>
<td>Echo guide for biopsy</td>
<td>$175.90</td>
<td>$39.59</td>
<td>$-136.31</td>
<td>-77.5%</td>
<td>-77.2%</td>
</tr>
<tr>
<td>76870</td>
<td>Us exam scrotum</td>
<td>$95.94</td>
<td>$41.37</td>
<td>$-54.57</td>
<td>-56.9%</td>
<td>-55%</td>
</tr>
<tr>
<td>76775</td>
<td>Us exam abdo back wall lim</td>
<td>$83.02</td>
<td>$36.38</td>
<td>$-46.64</td>
<td>-56.2%</td>
<td>-54.5%</td>
</tr>
</tbody>
</table>

**Direct Practice Expense Inputs for Stereotactic Radiosurgery (SRS) Services**

Since 2001, Medicare has used HCPCS G-codes, in addition to the CPT codes, for SRS to distinguish between robotic and non-robotic methods of delivery. In the hospital outpatient there are four priced G-codes that distinguish between robotic and non-robotic SRS. In the freestanding facility, CMS has priced two CPT codes that do not distinguish between robotic and non-robotic. The two G-codes that describe robotic SRS are carrier priced in the freestanding setting. After reviewing the current literature, CMS believes that it is no longer necessary to distinguish between robotic and non-robotic linac-based SRS through the HCPCS G-codes.

For CY 2014, CMS is not proposing to replace the contractor-priced G-codes for MPFS payment. Instead, they are seeking comment from the public and stakeholders about whether the direct PE inputs for the existing CPT codes (77372, SRS linear based and
77373, stereotactic body radiation therapy (SBRT) delivery) for MPFS payment would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery.

The ACR supports this proposal and agrees that using the CPT codes, instead of the G-codes, to describe all SRS and SBRT treatments is appropriate. All SRS and SBRT treatments, including robotic treatments, are appropriately captured with CPT codes 77372 and 77373. These codes have been recently reviewed by the AMA/RUC. CPT code 77372 was reviewed in April 2013 and CPT code 77373 was reviewed in January 2013. As part of this review of direct PE inputs, all technologies, including those with robotic functionality, were incorporated. In addition, equipment invoices for all of these technologies were included with the AMA/RUC’s submission to CMS. The price for the SRS system, CMS equipment code ER083, is the result of weighting six different treatment systems.

**Misvalued Codes**

CMS is proposing CPT code 76942 (Ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as a potentially misvalued code because of a contractor medical director’s (CMD) concern regarding the high frequency with which it is billed with CPT code 20610 (Arthrocentesis aspiration and/or injection; major joint or bursa (for example, shoulder, hip, knee joint, subacromial bursa). The proposed rule states that the CMD raised concerns “because of the high frequency with which it is billed with CPT code 20610 (Arthrocentesis aspiration and/or injection; major joint or bursa (for example, shoulder, hip, knee joint, subacromial bursa) in the CMD’s geographic region”. The CMD noted that some providers within the contractor’s geographic area bill CPT code 76942 with every injection or aspiration of the knee. The national data differ from the CMD’s experience. According to data used by the RUC, when 20610 is reported, 76942 is also reported on the same patient on the same day only 5 percent of the time (2011 Medicare data). Therefore, the CMD’s local experience would seem to be an outlier or is perhaps anecdotal. Either way, the issue relates to circumstances beyond the purview of payment policy such as fraud and abuse. The ACR values the input of CMDs and the public regarding potentially misvalued services; however, we encourage the agency to confirm local and anecdotal experience with actual national data before requesting this level of additional public comment.

CMS also requested comments on a list of seven additional ultrasound guidance codes (Table 12) to be reviewed as potentially misvalued. The ACR does not believe that CPT code 76936 (Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging) should be included on this list. It is not the same as the other ultrasound
guidance codes in that 76936 is used to identify and then compress a vascular pseudoaneurysm and is generally reported by itself, not with an accompanying surgical code. Therefore, no "fundamental concern" should be present regarding the incentive to use ultrasound guidance for a pseudoaneurysm compression since this is the only way to accurately perform this compression procedure. Since this procedure is performed due to complications of complex catheterization procedures, we do not believe utilization of this procedure to be the result of a price driven overutilization. In fact, the data shows utilization of this code has been stable for a number of years having peaked in 2005. Utilization in 2012 was 18.5 percent less than 2005 so there is no other reason to think this code is misvalued. The ACR recommends that the value of CPT code 76936 be maintained.

**Revising the Medicare Economic Index (MEI)**

CMS proposes to revise the MEI, with the most significant change involving the reclassification of expenses for non-physician clinical personnel that can bill independently from non-physician compensation to physician compensation. This discretionary action, when applied to the pools of work and practice expense RVUs, leads to reductions in a majority of practice expense RVUs and a budget-neutrality adjustment to the conversion factor. The budget-neutrality adjustment also requires a commensurate reduction in the malpractice RVUs for all services. CMS estimates that the proposed revision in the MEI and its related effect on RVU pools will have no net impact on the specialty of radiology, but will lead to estimated reductions in Medicare payments of 1 percent for the specialty of interventional radiology, 2 percent for radiation oncology, and 5 percent for radiation therapy centers.

Further, the ACR believes the proposed reclassification of non-physician compensation itself is subject to debate. From the perspective of a physician group practice, we believe physician assistants and nurse practitioners would typically be in an employment relationship. Hence, their labor costs would be viewed by the typical practice as a practice expense. Thus, we believe there are grounds for continuing to treat these costs as non-physician compensation.

We also believe that the proposed reclassification of non-physician compensation and its resulting effect on RVUs have made it difficult for stakeholders to unravel the individual effects on practice expense RVUs of the several different provisions in the proposed rule. Across-the-board reductions in malpractice RVUs have led to additional confusion among stakeholders, especially since these reductions were not even acknowledged in the proposed rule. In fact, the entire section of the proposed rule focusing on the revisions to the MEI never once mentions the fact that the altered MEI weights will have a significant impact on the RVUs for individual physicians’ services. This matter is admittedly addressed in the regulatory impact analysis, especially in column (E) of Table 72 but,
despite its significance for many physician specialties, garners only a single sentence there.

The ACR is concerned about the proposed reclassification of non-physician compensation given its impact on Medicare physician payments. This is not just a technical matter or one affecting only future MEI calculations, but one having a significant effect on Medicare payments for individual physicians’ services. Further, a number of the specialties negatively affected by the proposed change would also be negatively affected by other provisions of the proposed regulation that would have the effect of reducing practice expense RVUs. This includes the increased utilization assumption for certain imaging equipment and the proposed cap on non-facility practice expense RVUs for certain services, based on Medicare payments for these services when furnished in ambulatory surgical centers or hospital outpatient departments. While the ACR recognizes that the proposed revision to the MEI will have a differential impact on physicians’ services, creating both “winners and losers,” we question the reasonableness of making this change at the same time as many other changes with significant impact on certain categories of physicians’ services.

Examples of the magnitude of reductions to the technical component reimbursement specific to the MEI reclassification affecting radiology and radiation oncology codes include: 93970 (Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study) 11.7 percent reduction, 74270 (Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB) 11.4 percent reduction, 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) 10.4 percent reduction, 77336 (Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy) 6.8 percent reduction, 77412 (Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV) 6.7 percent reduction, and 77295 (Therapeutic radiology simulation-aided field setting; 3-dimensional) 6.6 percent reduction.

In sum, the ACR urges CMS to reconsider the proposed reclassification of non-physician compensation as part of the proposed revision of the MEI for CY 2014.

Utilization Rate

While the ACR understands that the 90 percent utilization rate assumption within the MPFS proposed rule is a result of a statutory requirement within the ATRA, we continue to believe that this assumption is unsubstantiated. In 2009, the Radiology Business
Management Association (RBMA) conducted an imaging equipment utilization rate survey that found usage rates much closer to Medicare’s previous assumption of 50 percent and much lower rates for advanced imaging (e.g., CT, MR). The RBMA found that imaging equipment in rural regions of the country operates 48 percent of the time an office is open for business, while equipment in non-rural areas operates 56 percent of the time a center is open for business. In 2010, the Access to Medical Imaging Coalition (AMIC) expanded on the RBMA survey and found even lower equipment utilization rates.

The equipment utilization rate increase combined with the change in the practice expense methodology for determining equipment room time creates “double jeopardy” reductions. The equipment room time is a direct expense within the PE Methodology and an important contributor to the total PE RVUs for capital intensive specialties like radiology. The CMS standard for equipment time, such as an MR scanner, is the time the MR scanner is unavailable for use by other patients. The ACR has long recommended that the MR scanner should be considered unavailable to the next patient while the MR technologist completes the current patient. This makes sense for best patient care and previously CMS agreed. However, in 2013, CMS lowered the MR room time by removing the time associated with certain technologist activities, such as obtain consent and process images. In other words, CMS assumes the MR technologist can work on two patients at once, an assumption made even more suspect by the concurrent assumption that the MR scanner is in use 90 percent of the time. These new time allocations caused a decrease in the MR room time of almost 50 percent contributing to the sharp decline in TC payment between 2012 and 2013. These reductions will be compounded by the 90 percent utilization rate in 2014.

To help the Agency better appreciate the magnitude of the reductions to the technical component of imaging services specific to the 90 percent utilization rate, we provide the following examples: 70546 (Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences) 15.5 percent reduction, 75565 (Cardiac magnetic resonance imaging for velocity flow mapping) 13.5 percent reduction, and 72195 (Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s) 13.1 percent reduction.

**Multiple Procedure Payment Reduction**

The ACR appreciates that CMS has not proposed any further expansion of the MPPR policies for imaging services for CY 2014 and considers this to be an appropriate decision. However, we again would like to emphasize and reiterate our previous comments that the application of the MPPR to the professional component (PC) of diagnostic imaging services is inappropriate especially as it applies to multiple physicians in the same group practice.
CMS has stated that the application of an MPPR to the PC of radiology services was done to maintain consistency with policies pertaining to other services, in particular surgical procedures. However, we believe that this is inappropriate since the global period for surgical codes are typically 10 or 90 days, whereas imaging codes are usually XXX. Accordingly, the efficiencies captured in the pre and post service period of surgical codes are simply non-existent in XXX codes.

The ACR and the RBMA met with CMS staff last April to discuss and voice our concerns regarding the MPPR applied to the professional component across group practices as well as the impact of all of the various payment reductions radiology has seen over the past several years. The results of the paper, “Professional Efficiencies for Diagnostic Imaging Services Rendered by Different Physicians: Analysis of Recent Medicare Multiple Procedure Payment Reduction Policy”, published in the Journal of the American College of Radiology, were presented.

In 2011, the JACR published a peer reviewed study, “Professional Component Payment Reductions for Diagnostic Imaging Examinations When More Than One Service Is Rendered by the Same Provider in the Same Session: An Analysis of Relevant Payment Policy”, which shows actual efficiencies ranging from 2 to 5 percent (depending on the modality) when more than one study is interpreted by the same provider during the same session. The follow-up study (Professional Efficiencies for Diagnostic Imaging Services Rendered by Different Physicians: Analysis of Recent Medicare Multiple Procedure Payment Reduction Policy) proves actual efficiencies between 1 to 2 percent (depending on the modality) when examinations are interpreted by different physicians in the same group practice. Both studies show efficiencies which are an order of magnitude below CMS estimates, and we have made repeated requests to view and analyze the data CMS references through rule-making as the basis for your conclusions.

QUALITY PROVISIONS

Physician Compare

CMS describes its plans for the continued development of the Physician Compare Website and invites comments on its proposals to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice. Included in those plans are various proposals for posting performance data of groups and individual physicians on certain quality measures collected under the Physician Quality Reporting System (PQRS).

The ACR suggests that CMS should move forward very carefully with public reporting of performance data for each individual quality measure. Presenting the performance data
in a way that provides understanding of the measure focus across a potentially broad spectrum of individual patients requires thoughtful consideration. CMS should use both stakeholder and focus groups for developing and evaluating terminology for presenting measurement data to the public, in order to avoid misleading or alarming patients unnecessarily. While CMS is currently forming a Technical Expert Panel for Physician Compare, is it reasonable to expect to complete measure information on the substantial list of measures proposed to be publicly reported by 2015?

CMS also seeks comments regarding public reporting of participation by individual eligible professionals on initiatives such as Choosing Wisely on Physician Compare. The ACR believes that large scale initiatives such as Choosing Wisely may be appropriate for public reporting if there is an actionable element of the initiative, such as a pledge or documented change in practice. Examples of this include involvement in campaigns such as Image Wisely® and Image Gently®. Additionally, certain accomplishments or advanced certifications such as higher levels of accreditation should be considered for public reporting. The ACR has implemented “Centers of Excellence” programs for Diagnostic Imaging and Breast Imaging that entail meeting requirements above those for mandated imaging accreditation; such accomplishments would be appropriate for reporting on Physician Compare.

CMS also notes that in future years, it will consider expanding public reporting of, and seek comments on, measures that have been developed and collected by approved and vetted specialty societies for individual eligible professionals as well as data collected via the new qualified clinical data registry option being proposed under the PQRS. The ACR potentially supports this proposal following at least an initial evaluation of the measures available and with the same caveat that thoughtful consideration goes into the measure information presented to patients.

**Physician Quality Reporting System (PQRS)**

**Changes in Requirements**

*Increase in Measure Reporting Requirements*

CMS proposes increasing the requirement for successful reporting from three measures to nine measures. CMS proposes that when reporting through the claims mechanism, an eligible professional (EP) may report less than nine measures (1-8) if less are relevant to the services provided. For other reporting mechanisms, i.e. traditional qualified PQRS registry, electronic health record (EHR) or the new qualified clinical data registry option, CMS does not propose to allow reporting on a number of measures less than nine.
The ACR believes that CMS must surely recognize how problematic meeting this proposed requirement will be for many groups and individual EPs. For many specialists and most sub-specialists there are not enough relevant measures to meet the current requirement of three measures. In addition to that challenge, asking physicians to scramble to report on a number of measures vaguely relevant to their practice is overly burdensome. It is also difficult for physicians to understand and realize that there are PQRS measures that technically apply to their practice because of measure codes, when at first glance a measure may seem totally irrelevant. An example is an interventional radiologist reporting on smoking cessation or weight loss measures, when patient contact is limited in a setting where those discussions would be practical.

The new qualified clinical data registry (QCDR) option offers hope for providing physicians with meaningful and potentially plentiful reporting and measurement opportunities. However, to require reporting of nine measures through the QCDR mechanism in the initial year of that option being available is not practical. Even for currently existing, robust clinical data registries with a library of nine or more measures, expecting that those nine measures would be reportable by all sub-specialists potentially using the QCDR is unlikely. For physicians to gear up so quickly from three to nine measures is, again, overly burdensome.

To summarize points regarding measure requirements for using a traditional registry or qualified clinical data registry (no option for fewer than nine measures, as for claims):

- Too much disparity between requirements for EP using claims – although the ACR appreciates CMS maintaining the claims option for reporting less than 9 (or 3 currently).
- QCDR must be able to collect/report on 9 measures, but does not mean all 9 are relevant to each individual EP participating in the QDCR. Same issue as with individual PQRS measures, e.g. sub-specialization and availability of measures.
- Too large a jump from 2013 to 2014 requirements – measures available for reporting does not support that increase.
- Too many measures for first year of QCDR. Will prevent many specialists from using option due to lack of relevant measures available as societies/organizations work towards developing a registry that meets proposed requirements. Although QCDR should open up reporting opportunity, it will be several years before many EPs will benefit from emerging QCDRs.
- The ACR suggests reducing the number of measures required in 2014 to 4. Consider phasing in increase by varying reporting requirements for avoiding penalty and obtaining incentive.
It is also not clear how the QCDRs will come into play in terms of assessing available measures an EP has for reporting. Can an EP report on three measures through claims reporting and six through a QCDR, doing so because that is the only way the nine measure requirement can be met? The measures reported through a QCDR may not necessarily be linked to claims for services and/or diagnosis billed, which is how CMS currently determines opportunity to report using the measure applicability validation process. How will CMS assess if measures included in a QCDR are reportable by an EP?

**Reporting exemption**

Moving so rapidly to an increased reporting requirement in the second payment adjustment performance year (2014 for 2016 adjustment) from an almost lax requirement in the initial year (2013 for 2015 adjustment), where EPs are only required to report one measure to avoid the penalty is drastic. For the 2013 PQRS reporting year/2015 PQRS penalty year, the Administrative Claims-based option has the effect in some cases of serving as a reporting exemption, in that an EP can elect that option, as a last resort if the EP has no measures to report, even though the measures are irrelevant to the practice, and avoid the 2015 penalty. Along with the increased reporting requirements, there is no such option available in 2014 to avoid the 2016 penalty. Does CMS have plans for a method that allows an EP to “declare” their inability to report, perhaps similar to the hardship exemption process for the eRx Incentive program or the EHR Incentive program? The ACR urges CMS to consider an exemption for EPs who cannot report any measures in 2014. There should be some way that individuals or groups can indicate to CMS that they are not reporting because they have no measures to report, so that they will not be considered “non-PQRS reporters” subject to the -2.0 percent PQRS penalty and the -2.0 percent VM penalty. Since measures may be available in the future that the EP/group can report and be a participant in reporting, this may need to be an annual exemption request by the EP/group if in the prior year the EP/group claimed that there were no measures available to report.

**Measures group reporting**

CMS proposes to limit measures group reporting to registry only and to remove the option of reporting measures groups through claims. With the increased requirement for nine measures for registry reporting, this will make it problematic for many individual radiologists to report the new Optimizing Patient Exposure to Ionizing Radiation (OPEIR) measures group, which has 6 measures, unless there are 3 other measures the EP can report, whereas with claims reporting an individual can report a measures group and meet requirements. This is likely the same case for many specialties with measures groups available for reporting only through a registry. So, while there are additional options for individual physicians participating in PQRS to use these measures groups, physician groups do not have the same advantage. Why is this necessary? Why shouldn’t
groups (GPRO) be allowed to report measures groups? And similarly, **limiting new measures groups to be reportable as only measures groups and not as individual measures reduces opportunity.** It seems that many of the measures within older measures groups are reportable as individual measures. What is the rationale for this? If CMS allows measures within measures groups to also be reported individually then both individual EPs and groups will have more available measures and greater flexibility in their reporting opportunities. Please see group practice reporting option (GPRO) section below for more.

**Proposed Measures**

In CY 2013 rule-making, CMS finalized inclusion of five measures from the new Optimizing Patient Exposure to Ionizing Radiation (OPEIR) measure set (developed collaboratively by ABMS/ABR/ACR/AMA PCPI) as a measures group. To report a measures group an individual EP must report all measures in the measures group. CMS did not finalize the option of reporting these as individual measures.

As a co-developer of the measure set, the ACR is pleased that these measures are slated for use in PQRS next year. However, since the OPEIR measures are structural in nature, and because the technology used or system enhancements that may need to be implemented to meet the measures will likely be done at least at a group level and in many situations in conjunction with a facility, implementing the measures for use by groups under the GPRO option makes sense for these important measures. **Allowing an option to report the OPEIR measures as individual measures, so that GPROs can report them, or so that individual radiologists may work together with their groups or facilities to implement technology would be a better solution.** A potential option is to include the OPEIR measures in a QCDR, to allow reporting select measures from the OPEIR group.

**Qualified Clinical Data Registry (QCDR)**

CMS describes its proposals for implementing the newly authorized PQRS clinical data registry for individual eligible professionals to satisfy PQRS beginning in 2014. CMS believes that a “qualified clinical data registry” should serve additional roles that foster quality improvement in addition to the collection and submission of quality measures data. CMS enumerates requirements that a clinical data registry should possess to be qualified.

Overall, the ACR is pleased with the approach CMS has proposed for implementing the clinical data registry option. We are hopeful that the newly authorized option will give physicians the opportunity to participate in meaningful quality improvement and measurement activities, at the same time allowing them to avoid payment penalties or
qualify for incentives. These registries are likely to provide for a timely, meaningful and relevant performance cycle that could make a real impact on improving quality and lowering costs. An expanded library of assessment and measurement tools can provide physicians with improvement opportunities through directed learning on identified performance gaps, and at the same time serve readily for value-based comparisons and consumer choice in quality reporting programs. ACR membership has individually, within their institutions, through their health systems, and in conjunction with regional health organizations implemented top-notch quality improvement programs across the country. To allow these activities to potentially be recognized as meeting PQRS requirements is encouraging.

QCDR Requirements

While more detailed information would be useful, the ACR believes the proposed requirements, from the standpoint of implementing a QCDR, are reasonable - particularly in that the first year (2014) for implementation is such a rapid turnaround. The ACR initially had concerns that CMS would require that a clinical data registry include outcomes measures of a very strict sense, closely tying physician behavior or performance to a direct patient outcome. Such outcomes based measures should not be a requirement and would not address many areas where improved patient outcomes may be achieved by certain specialists, particularly diagnostic radiologists. Although CMS has outlined a requirement that a QCDR must include an outcomes measure, the ACR was pleased that the CMS description of such a measure is broad: assesses the results of health care that are experienced by patients - clinical events, recovery and health status; experiences in the health system; and efficiency/cost. Such a measure may be reasonably designed for radiology and not preclude a radiology society-based clinical data registry from being qualified.

Requiring National Quality Forum (NQF) Endorsement for QCDR Measures

CMS discusses in the proposed rule the utility and benefit of requiring QCDR measures to be NQF endorsed. CMS notes statutory requirements for measures in the PQRS program to be NQF endorsed with some exceptions allowing CMS discretion, which CMS has used in the past. CMS proposes that a QCDR must include and report on a set of measures from several categories, including, but not limited to, NQF endorsed measures.

The ACR believes that CMS has interpreted the statute allowing use of QCDR for PQRS broadly and is pleased that the Agency is allowing a good deal of flexibility in terms of measures that a QCDR will be allowed to use, specifically that CMS is not requiring that the measures be NQF endorsed. While NQF endorsement can be worthwhile, this requirement has also resulted in a limited number of measures available for use in PQRS.
Such a requirement would hamper the benefits of using specialty society registries. Flexibility is needed. Currently, physician engagement is challenging without the additional barrier to implementing relevant measures. CMS acknowledges that “clinical data registries would know best what measures should be reported to achieve the goal of improving the quality of care furnished by their eligible professionals” (within certain parameters). The ACR and other specialty societies have voiced appreciation to CMS in that regard. Specialty societies will be putting competed-for resources into QCDR development. CMS should recognize that resources will be put into development of products that are meaningful, relevant and support improvement.

**QCDR Participation Requirements**

CMS proposes that a QCDR should provide comparative benchmarking of participants, preferably using a national benchmark, but across registry participants is acceptable. The QCDR must also enable public reporting of performance rates on individuals participating. The ACR believes that overall, QCDR successful participation requirements seem to be reasonable, except for the aggressive requirement of reporting nine measures. As noted in our prior comments in this letter, the ACR strongly urges CMS to consider increasing the requirement to report four rather than nine measures in 2014. Please review our discussion above in the section on “Changes in Requirements”.

**Patient Level Data**

CMS-proposed requirements for a QCDR include the ability of the registry to perform audit functions based on patient identifiers. CMS was not specific as to what patient identification data is necessary.

In assessing requirements for a QCDR in terms of patient identification data necessary to perform audit functions, the ACR believes it is reasonable to limit this data to age, gender, insurer, study/exam date, study/exam time. From that information an EP can identify exams and verify patient cases for audit purposes. Beneficiary ID is generally not readily available at the time a service is provided; the beneficiaries IDs are appended during billing. A beneficiary ID requirement would be burdensome for facilities to submit in a reliable way when collecting data for quality improvement (QI).

As an alternative to submitting quality data on each EP, CMS is proposing that for the 2014 reporting period only, that the QCDR provide CMS with a list of EPs (with TIN/NPI info) that participated in and reported quality data to the QCDR, in order to determine satisfactory participation for the 2014 PQRS incentive and 2016 Payment Adjustment. CMS is considering this because they lack experience with collecting QCDR data, and need the time to build their data infrastructure. The ACR supports this
alternative, particularly for new registries. In addition to giving CMS more time to build an infrastructure, it also allows for better testing of transmission mechanism and links. This might alleviate some of the anxiety an EP may have in participating in a QCDR without knowing for sure if a registry was qualified until fall of the reporting year.

**Group Level Participation**

CMS has proposed to implement a QCDR for use in PQRS reporting for individual EPs, but not for the Group Practice Reporting Option (GPRO). The proposed rule was silent on this discrepancy.

The ACR sees a need and use case for groups to participate in quality improvement activities using a clinical data registry. As mentioned above in the section on “Proposed Measures”, certain measures (such as the OPEIR set) more inherently lend themselves to group or facility level participation. In that vein, some specialty boards, including the American Board of Radiology (ABR), allow individual physicians to meet Maintenance of Certification Part IV requirements by participating in quality improvement projects as a group project, within certain parameters. The ABR considers any individual who participated in a group quality improvement project to have met individual requirements. The ACR currently maintains its clinical registries as approved ABR Part IV projects, and for use by groups. The nature of several of the ACR registries largely lend themselves to use by groups, with the same reasoning as described for the OPEIR measures above. Therefore, we believe that group participation in QCDR measures should allow individual physicians in that group to meet PQRS reporting requirements.

**Group Practice Reporting Option (GPRO)**

CMS outlines several proposed modifications and continued requirements for using the GPRO, including the ability for GPROs to report PQRS quality measures using either the registry or EHR-based reporting mechanisms. CMS also proposes to modify GPRO satisfactory reporting criteria to mirror the proposed changes for individual EPs, that is, groups of 2 or more physicians must report at least 9 measures covering at least 3 of the National Quality Strategy domains, AND report each measure for at least 50 percent of the group practice’s applicable patients seen during the reporting period to which the measure applies, and measures with a 0 percent performance rate will not be counted. This criterion would apply for purposes of both the 2014 PQRS payment incentive and the 2016 PQRS payment adjustment. However, **CMS does not propose to allow GPROs to report measures groups, as allowed for individual EPs.**

The ACR certainly sees the benefits and utility of group reporting under the GPRO, and was encouraged in CY 2013 rulemaking that CMS allowed GPROs to report traditional PQRS measures using a registry, rather than only the Web interface mechanism that
contains basically primary care measures. However, limiting GPRO groups to using only individual measures reduces the opportunity for more physician groups to participate under the GPRO option. The ACR finds the discrepancy between requirements for individual EPs and GPROs confounding. Those thoughts are outlined below:

- **Why can’t GPROs use QCDR or report measures groups?**
  - As mentioned above, some measures (e.g. structural such as OPEIR) may make more sense at group level; if one person in a group can accomplish the measure most likely everyone can.
  - Measure group reporting is less burdensome because of the 20 patient sample size.
  - MOC Part IV allows group level activity; certain individual requirements (QI meetings) exist but project counts for everyone. These “group” projects may be available through QCDRs as measures.
  - Measure performance rates may be more statistically accurate at group level due to denominator size (e.g. cancer detection rate, positive predictive value).

- **There is a disconnect between the option for GPROs to meet PQRS/Value Modifier (VM) requirements (nine measures/50 percent reporting sample) and the 70 percent threshold of the group (non-GPRO) option for avoiding the value modifier penalty (70 percent of individuals in group must satisfy PQRS).**
  - GPROs cannot report measures groups.
  - GPROs cannot use a QCDR.
  - These two factors limit the number of measures that a radiology GPRO can report (probably many other specialties too). Thus, some groups may not be able to use the GPRO due to lack of measures available across everyone in the group.
  - GPROs (and each individual in the group) can avoid both the PQRS and VM penalty without minimum threshold of individuals in group reporting measures, so that may be a good solution for groups who have high number of individuals who cannot report nine measures, but a few who can.
  - In non-GPRO groups (threshold of 70 percent of individuals in group report), individuals can report measures groups and use a QCDR. This option will enable the group to avoid the VM penalty (but the 30 percent that do not report PQRS will have a PQRS penalty, unlike GPRO option where entire group avoids PQRS penalty). The 70 percent option also allows individuals to still report using claims without needing to report nine measures (if only 1-8 are applicable). But measures groups can only be reported through a registry (proposed for 2014) which means that individuals reporting a measures group would have to find three more
measures to report because of hard requirement for nine measures for registry reporting. 70 percent of group many find this problematic.

Weighing all the pros and cons across PQRS and the VM for the varying reporting scenarios is complicated and confusing. To summarize:

- **GPRO**: no minimum threshold of individuals in group reporting, enables avoidance of both the PQRS and VM penalty, if the group as a whole can find enough measures (nine proposed), without option for reporting measures groups or using a QCDR.
- **Non-GPRO groups**: not an option for everyone in the group to avoid a PQRS penalty (as GPRO reporting is); members in group that don’t have enough measures (1-9) will have -2 percent PQRS penalty, but entire group can avoid VM penalty even if 30 percent don’t have or don’t report measures (get PQRS penalty); allows use of claims, registry (and measures groups) or QCDR.

The ACR believes that few radiology groups will be able to meet the proposed requirements in 2014 and that a great deal of education will be needed to assist radiologists and other physicians in understanding their options. **The ACR strongly urges CMS to consider the following options and potential resolutions:**

1) **Raising the number of measures required to 4 for registry and QCDR reporting, rather than nine as proposed.**
2) **Allowing the same non-GPRO group option (70 percent threshold) for avoiding PQRS penalty.**
3) **Allowing GPRO to use measures groups or QCDR.**

These changes could increase the number of individuals/groups with either more measures to report or less of a chance of having penalties due to lack of measures. **CMS should continue to allow measure group reporting through claims, particularly if registry reporting is finalized with a nine measure requirement.**

Plan for the Future of PQRS for the 2017 PQRS Payment Adjustment and Beyond

**GPRO Multiple TINs**

CMS is taking into consideration and seeks comments regarding concerns that their GPRO definition (2+ EPs in a single TIN) is restrictive to business practices of many groups that hold multiple TINs but are a single entity.

The ACR supports a change to allow groups that hold multiple TINs to participate in PQRS as a single group.
Phase out of Claims Reporting

CMS is proposing to remove the claims based reporting option in 2017, as registry and EHR reporting become more widely used. CMS stated that in 2011, 72 percent of PQRS reporters used claims based reporting.

The ACR recommends that CMS maintain the claims reporting mechanism until a substantial majority, perhaps 90 percent, of EPs can utilize another option. While we recognize the limitations that claims reporting places on measure constructs, under current requirements the claims based mechanism not only provides a low-cost, effective means of reporting, it also allows EPs who have less than the full requirement of measures to report (currently three, proposed nine) to successfully participate. CMS must reconsider the proposal or alternatively create an exemption mechanism for EPs without measures or few measures available to report.

Integration of CQMs from Hospital Inpatient Quality Reporting program (IQR)

CMS has proposed to include in PQRS several measures currently used in the Inpatient Quality Reporting (IQR) program. CMS suggests these measures may be “retooled” to apply at the individual physician level rather than the facility level, and believes the measures would provide “statistical data representing care provided by individual EPs”. By including these measures, CMS is responding to feedback from hospital based physicians who believe that PQRS measures do not adequately capture the nature of their practice. CMS is suggesting that a physician could choose to have these measures used in their PQRS reporting.

The ACR suggests that, in a similar fashion, the Imaging Efficiency measures from the Hospital Outpatient Quality Reporting (HOQR) could be used by individual physicians in PQRS. This may be acceptable if provided as a choice to the physician. However, before implementing the measures in PQRS in this way, physicians should have an opportunity to see what their performance rates might be before they are used for the VM quality-tiering.

EHR Incentive Program – CQM Reporting and Qualified Clinical Data Registry

CMS has proposed that a QCDR may be used for reporting clinical quality measures (CQMs) for the EHR Incentive programs under certain parameters; including that the measures must have been finalized as CQMs under Stage 2, the EP must also ensure that the registry selected is certified for the functionality that it is intended to fulfill and is a certified EHR module that is part of their certified electronic health record technology (CEHRT). As proposed, if the data registry is performing the function of data capture for
the CQMs that would be submitted to CMS, then the registry needs to be certified to the “capture and export” criteria. CMS intends to revisit the certification criteria with the Office of the National Coordinator for Health Information Technology (ONC) in the Stage 3 rulemaking to develop a more flexible clinical data registry reporting option and certification criteria for the EHR Incentive Program.

The ACR supports more flexible QCDR certification criteria for the EHR Incentive program.

**Value-based Payment Modifier (VM) and Physician Feedback Program**

CMS proposes substantial changes to the Value-based Payment Modifier (VM) program in order to meet statutes requiring implementation of the VM for all physicians by CY2017, including:

- Apply the modifier to groups of physicians with 10 or more eligible professionals in CY 2016.
- Make quality-tiering mandatory for groups within Category I for CY 2016. Groups of physicians with between 10 and 99 eligible professionals would only be subject to upward or neutral adjustment and groups of physicians with 100 or more eligible professionals would be subject to upward, neutral, or downward adjustments.
- Increase the amount of payment at risk from 1.0 percent to 2.0 percent in CY 2016.
- Align the quality measures and quality reporting mechanisms with those available to physician groups under the PQRS during the CY 2014 performance period.
- Include the Medicare Spending Per Beneficiary (MSPB) measure in the total per capita costs for all attributed beneficiaries domain of the cost composite
- Refine the cost measure benchmarking methodology to account for the physician specialties within a group.

**Group Size**

CMS has proposed a significant change regarding group size for those groups to be subject to the value modifier in 2016. Currently, groups of 100+ EPs are subject to the VM in 2015 based on 2013 reporting. CMS is proposing that groups of 10+ EPs will be subject to the VM in 2016 based on 2014 reporting. According to CMS calculations, this means the VM will affect about 60 percent of physicians billing under Part B.

Additionally, CMS proposes to make quality-tiering (QT) mandatory for all groups participating satisfactorily in PQRS (Category 1 groups) for the 2016 VM, but groups of 10-99 will only be subject to an upward or neutral (0 percent) payment adjustment while groups of 100+ will have payment at risk based on performance. Groups that do not
participate satisfactorily in PQRS (Category 2) will have a -2.0 percent payment adjustment, an increased penalty from -1.0 percent for the 2015 payment adjustment.

The ACR sees this proposal as a substantial increase in the number of groups that would be affected by the VM. Although CMS proposes that groups under 100 would not be subject to a downward value modifier in 2016 if they are successful at avoiding the PQRS payment adjustment, the proposed increased PQRS reporting requirements (nine measures) would make it more difficult for groups to avoid the payment adjustment. Even though CMS is proposing an additional way for groups to succeed (70 percent threshold), there are the issues with group reporting mentioned above (GPRO versus non-GPRO groups). Again, the ACR strongly urges CMS to not implement such a steep increase in reporting requirements; an increase to nine measures is premature. In addition, broadening the implementation of the VM to groups of 10 or more EPs so quickly is premature before CMS has had the opportunity to truly assess the impact on smaller groups. The ACR asks CMS to reconsider their proposal and suggests changing the group size affected by the 2016 VM to groups of 25 or more EPs.

Setting the VM Adjustment Based on PQRS Participation

CMS proposes to modify the current requirements for eligible groups (10+ EPs) for how PQRS participation will affect VM calculation for CY2016 as shown below:

- **Quality-Tiering (QT) Category 1:**
  1) Self-nominated GPRO who meet the criteria for satisfactorily reporting PQRS data for avoiding the CY 2016 payment adjustment using web interface, EHR or registry reporting (eliminating the administrative claims based option)
  2) Groups in which 70 percent of the individual EPs have satisfactorily reported PQRS using claims, registry, EHR or satisfactorily participate in a qualified clinical data registry (QCDR).

  CMS believes the 70 percent threshold is reasonable because 1) it will give a reliable indicator of the group’s quality, 2) the majority of EPs participate in PQRS as an individual and 3) based on analysis of 2011 PQRS data, 63 percent of groups with less than 50 EPs (TINs) participating in PQRS would have met the 70 percent threshold.

- CMS also proposes that all groups in Category 1 would be subject to mandatory quality-tiering for the CY 2016 VM (unlike CY 2015 VM where groups can elect QT), except that groups of 10-99 EPs would only be affected by an upward or neutral payment adjustment. Groups of 100+ EPs would also be subject to a downward adjustment under quality-tiering.
CMS believes this proposal would reward groups providing high quality/low cost care, reduce program complexity and more fully engage groups as the VM is implemented.

- For groups of 100+ EPs CMS proposes to begin implementing both the upward and downward payment adjustments, in conjunction with their proposal to make quality-tiering mandatory. For CY 2015 payment adjustment, these large groups would be subject to either upward or downward adjustments, but have the option to elect QT or not. CMS seeks input on whether they should use the same quality-tiering approach for groups of 100+ that they have proposed for groups of 10-99 (mandatory QT but no downward adjustment).

Category 2:
Groups of 10+ that do not fall into Category 1 would be subject to a VM payment adjustment.
CMS seeks comments on these proposals.

CMS is proposing to increase the VM penalty for Category 1 groups and Category 2 groups in the lowest quality tier from -1.0 percent to -2.0 percent for 2016. The first cohort of groups (100+) faced with the VM penalty in 2015 is subject to the -1.0 percent for non-participation in PQRS, with a second year increase (2016) to -2.0 percent. The second cohort of groups (10-99) are potentially faced with -2.0 percent in their initial VM penalty year. Perhaps this is to enable budget neutrality in providing upward adjustments for a larger number of groups, but it is more equitable to ramp up the new cohort of groups similar to the first cohort (first year -1.0 percent, second year increase to -2.0 percent), particularly since those groups are also facing steeper PQRS reporting requirements in their initial VM year. Alternatively, the VM bonus payments could be tiered by the number of measures reported as well, for example, report on six PQRS measures for a +1 percent upward adjustment, or report on nine for a +2 percent upward adjustment.

Performance Period and Timely Feedback

CMS is working towards providing more timely feedback to physicians for purposes of the VM through the Quality Resource Use Report (QRUR). In September 2013, groups of 25+ will receive the QRUR for the CY 2012 performance period, nine months after the performance period closes. CMS is enhancing infrastructure to enable providing reports sooner and expects to provide the 2014 QRURs even sooner.

Unlike PQRS where the incentive has been dependent on reporting satisfactorily, the VM program penalties and incentives (through quality-tiering) are tied to measure performance rates. This makes timely performance feedback from CMS more important, in that EPs need to know where they stand as early as possible in order to modify
practices, if appropriate, to improve measure rates upon which reimbursement factors will be tied.

The gap between when reports are available and the end of the performance period is due in part to a full year performance period that extends 3 months past the end of year to allow for claims run out and obtaining data from registries. To allow faster turnaround of reports, CMS seeks comments on shortening the performance period, using multiple years, or breaking into quarterly performance periods.

**The ACR agrees with CMS that more timely feedback is important.** Truly effective feedback must be available in rapid cycle, with quarterly being a minimum. Quarterly reporting with a short time lag is ideal if practices are to be able to understand how they are doing and to change accordingly. However, a rolling 12 month cycle reported on a quarterly basis might be most effective, particularly for measurements with small sample populations where a longer period of time might be required to show any improvement.

**Cost Measures – Medicare Spending per Beneficiary Measure (MSPB)**

CMS has proposed using the MSPB measure in the VM cost composite beginning in CY 2016. The measure is currently used in the inpatient quality reporting program (IQR) and Hospital Value Based Purchasing program. CMS proposes to use the MSPB to assess physician performance related to costs of acute inpatient hospitalization and post-acute care based on an index hospital admission. Any physician who has billed for Part B services during an index admission will have that admission attributed to the group and the MSPB will be calculated for the group’s cost composite (with a 20 case minimum attributed to the group for including the measure in the composite score). The same admission could be attributed to more than one group. CMS has proposed using only costs for services during the inpatient stay or alternatively for the entire 3 days prior – 30 day post hospitalization. The costs attributed to the group will be the total index admission costs, not just the services provided by the group.

**Attribution**

CMS proposes several alternatives for implementing the measure:
1. Multiple group attribution to any group providing Part B services, inpatient costs only or entire index episode (as described in above paragraph)
2. Single group attribution of costs to group with plurality of Part B services for the entire episode or for inpatient costs
3. Hybrid attribution of costs to groups with at least 35 percent of Part B services either inpatient only or entire episode
Currently there are no cost measures in the VM cost composite that are attributable to radiology groups. As it stands now, CMS has proposed that groups for which CMS is unable to calculate a cost composite will be classified as having “average cost” under the quality-tiering methodology. If CMS implements the MSPB attribution methodology in #2 or #3 above, it is unlikely that many radiology groups would have the MSPB measure counted in their cost composite, resulting in a default score of “average cost” (although #3 could result in measure attribution for imaging heavy admissions). The method in #1 would result in the MSPB measure being attributed to many radiology groups. With that method, for 2016 VM, for radiology groups of 10+:

- The MSPB measure would be the only cost measure potentially scored in a radiology group’s cost composite, so it would be weighed as 100 percent of the cost composite score.
- High, average or low cost would be dependent on that measure alone, until such time other cost measures attributable to radiology groups are developed.
- MSPB cost scores are dependent on every provider (Part A or B) that contributes services to a beneficiary during the index admission.
- For VM 2016, Category 1 groups of 10+ (PQRS reporters) are only subject to an upward or neutral VM, so even if their MSPB measure score is “high cost” they will not have a negative adjustment.
- For those groups in 2017, the VM will likely be -1.0 percent for low quality/average cost and -2.0 percent for low quality/high cost, so the MSPB score will have more impact.

The ACR tentatively supports use of the MSPB measure with attribution described in Method 1 above. However, before being implemented to affect the actual VM quality-tiering payment (upward or downward), physician groups should have experience with the measure through inclusion in their QRUR. Groups should have the opportunity to assess the implications, accuracy, and understand the best approach for implementation, particularly if the MSPB measure is the only cost measure in the composite for which the group will be measured. Additionally, as a whole CMS needs more experience with the measure and its potential impact on physician services.

**Conclusion**

The ACR is extremely concerned about the complex nature of this proposed rule and the impacts on radiology and radiation oncology as a result of multiple factors both within the MPFS proposed rule and the OPPS proposed rule. Given the impact on the MPFS, we request that CMS not finalize the CT and MR cost center proposal within the OPPS proposed rule, and we have submitted this request in our comment letter on the OPPS proposed rule as well.
The ACR also requests that CMS not finalize the new proposed OPPS/ASC cap. The proposed rule provides too little detail about exactly what CMS is proposing and it took considerable time during the comment period to obtain the information needed to understand and replicate the CMS methodology, especially with respect to the five percent “low volume” threshold and whether payment for a specific code was being capped at the ASC or OPPS levels. The proposed rule itself did not even include a list of affected codes but instead directed readers to Addendum B, which is simply a complete list of all codes paid under the Medicare physician fee schedule. The ACR feels that the proposed policy is inappropriate and asks that it not be finalized.

With the number of various impacts to radiology reimbursement including the DRA, the statutory change in the equipment utilization rate, interest rate changes, changes in practice expense inputs, the physician practice information survey (PPIS) and the MEI, the ACR urges CMS to consider implementing a reimbursement dampening policy. Imaging services have been subject to these and numerous other policies which have greatly reduced reimbursement rates since 2006, and the ACR remains deeply concerned that these latest proposed cuts to imaging services will further undermine radiologists’ ability to provide the high quality patient care which is our standard. It is important that CMS recognize the cumulative impact of the various legislative and regulatory policies reducing reimbursement of imaging services. If the proposed policies for 2014 are implemented patient access will be adversely affected. A dampening policy would limit the total amount a specific procedural code could be reduced in a given year.

The ACR appreciates the opportunity to provide comments on the CY 2014 MPFS proposed rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process in order to create a stable and equitable payment system. The ACR looks forward to continued dialogues with CMS officials about these and other issues affecting radiology. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Kathryn Keysor at 800-227-5463 ext. 4950 or via email at kkeysor@acr.org.

Respectfully Submitted,

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