January 24, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1600–FC
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; Final Rule with Comment Period

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) Final Rule.

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

- Impact of the Hospital Outpatient Prospective Payment System (OPPS) Rule on the Medicare Physician Fee Schedule for Radiology Services
- Using OPPS and Ambulatory Surgical Center (ASC) Rates in Developing Practice Expense (PE) Relative Value Units (RVUs)
- Misvalued Codes
- Practice Expense Issues
- Finalizing CY 2013 Work RVUs
- Finalizing CY 2013 Practice Expense RVUs
- Establishing CY 2014 Interim Final RVUs
- Multiple Procedure Payment Reductions (MPPR)
- Utilization Rate
- 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 again highlights data showing that total Medicare spending for medical imaging services has been on a steady decline. In April of 2013, 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 The ACR urges CMS to acknowledge this downturn and to advise its staff and carriers to not use the outdated language that pointed to a significant growth in spending when Medicare data shows the opposite trend.

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

The ACR remains concerned about the impact of the OPPS final 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. In the OPPS final rule, CMS decided to move forward and implement the use of the data from the CT and MR cost centers that hospitals have been reporting over the past few years even though ACR and other stakeholders have been alerting CMS to the fact that this data is flawed. CMS looked into the data further and decided to exclude the use of hospital data where CT and MR equipment costs were reported using the square feet method. Consequently, CMS gave hospitals four years to switch to the direct assignment or dollar value method for more accurate cost allocation. Despite this change, the impacts to CT and MR services are still great and, therefore, impact the MPFS payment rates for many of these same services due to the DRA cap.

CMS estimated an overall MPFS impact to radiology services of -2 percent; however, specific impacts at the code level are much greater. The ACR 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 nine Current Procedural Terminology (CPT®) codes that were not capped by the DRA in 2013, but face significant reductions in 2014.
<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>$126.45</td>
<td>$-37.20</td>
<td>-22.7%</td>
</tr>
<tr>
<td>71250</td>
<td>CT thorax w/o dye</td>
<td>$163.99</td>
<td>$126.45</td>
<td>$-37.54</td>
<td>-22.9%</td>
</tr>
<tr>
<td>72125</td>
<td>CT neck spine w/o dye</td>
<td>$166.37</td>
<td>$126.45</td>
<td>$-39.92</td>
<td>-24.0%</td>
</tr>
<tr>
<td>72128</td>
<td>CT chest spine w/o dye</td>
<td>$165.35</td>
<td>$126.45</td>
<td>$-38.90</td>
<td>-23.5%</td>
</tr>
<tr>
<td>72131</td>
<td>CT lumbar spine w/o dye</td>
<td>$164.67</td>
<td>$126.45</td>
<td>$-38.22</td>
<td>-23.2%</td>
</tr>
<tr>
<td>72191</td>
<td>CT angiograph pelv w/o&amp;w/dye</td>
<td>$319.48</td>
<td>$291.96</td>
<td>$-27.52</td>
<td>-8.6%</td>
</tr>
<tr>
<td>73200</td>
<td>CT upper extremity w/o dye</td>
<td>$163.31</td>
<td>$126.45</td>
<td>$-36.86</td>
<td>-22.6%</td>
</tr>
<tr>
<td>73700</td>
<td>CT lower extremity w/o dye</td>
<td>$163.99</td>
<td>$126.45</td>
<td>$-37.54</td>
<td>-22.9%</td>
</tr>
<tr>
<td>74175</td>
<td>CT angio abdom w/o &amp; w/dye</td>
<td>$320.16</td>
<td>$291.96</td>
<td>$-27.20</td>
<td>-8.8%</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 PE inputs. For example, in addition to the nine codes in the above table, CPT code 75571 (Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium) is experiencing a 56 percent decrease and 73718 (Magnetic resonance imaging lower extremity, without contrast material) is experiencing a 13 percent decrease.

The ACR and other stakeholder organizations participated in several meetings with CMS officials to relay our specific concerns about the CT and MR cost center proposal for the Inpatient Prospective Payment System (IPPS) and OPPS, which have since been finalized. We reiterate those concerns in our OPPS final rule comment letter.

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 vetted and 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 significant TC cut took 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 will 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.

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

The ACR commented in our letter on the proposed rule that we believed that the proposal to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the MPFS was inappropriate. We thank CMS for not implementing this flawed policy.

Costs for the CPT codes included in a given ambulatory payment classification (APC) may vary considerably, even more than two times in some cases (where the two 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 2014 MPFS proposed rule provided too little detail about exactly what CMS was proposing. 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 level. 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 MPFS. It was unclear how CMS applied the “Codes with Low Volume in the OPPS or ASC” exemption, as many impacted codes subject to the ASC cap fell below the 5 percent threshold in the ASC setting.

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. Yet 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. The proposal to cap some physician office services at ASC rates reflects 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.

CMS also reasoned 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 raised 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?

The ACR is further troubled by statements in the 2014 Final Rule such as:

“…we do not believe that the direct practice expense information we currently use to value these codes is accurate or reflects typical resource costs. …We believe the current review process for direct PE inputs only accommodates incomplete, small sample, and potentially biased or inaccurate resource input costs that may distort the resources used to develop nonfacility PE RVUs used in calculating MPFS payment rates for individual services.”

The ACR and other specialties spend considerable time and resources providing invoices and other documentation to reflect accurate pricing of equipment and shall continue to do so. If CMS differs, we encourage CMS to utilize its authority to either collect these data itself or hire a contractor to collect accurate pricing information that would validate the resource costs reviewed by the PE Subcommittee and approved by the RUC.
The practice expense methodology, for a number of reasons, has been unfair to radiology for several years, with some changes being mandated by Congress and others coming directly from CMS. Examples include the DRA of 2005, the flawed Physician Practice Information Survey (PPIS) survey and statistically invalid practice expense per hour (PE/HR) assigned to radiology, an impossible 90% assumption rate and an assumed interest rate which could not possibly apply to advanced imaging equipment. In fact, the CMS PE methodology only pays for 65% of direct expenses and as such, the direct input payments are already reduced. The 2014 Medicare Economic Index (MEI) reductions are largely based on data from the flawed PPIS and cause additional reductions to TC payments for advanced imaging services.

The ACR emphasizes that some of the impacted codes may be subject to the MPPR. Similar to what has been established with the DRA imposed OPPS cap, if CMS moves forward with a similar policy proposal, 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.

**Misvalued Codes**

**Validation Projects**

In April 2013, the ACR provided comments on the Statement of Work (SOW): Analysis of Physician Time Use Patterns under the Medicare Schedule, one of the two projects by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). In the comments, we relayed concerns of inaccuracies in the background section that biased the survey’s outcome and concerns of overall study design and statistical validity. The ACR has reviewed the distributed survey instrument and is disappointed. It does not appear that any of our concerns were taken into consideration.

In the survey instrument, there is no definition/explanation regarding what an "E/M" service is. Most radiologists do not provide E/M services so there is no reason a radiologist would understand the clinical conventions necessary to accurately answer the question at hand. Likewise, several survey questions relate to physician extenders such as physician assistants/nurse practitioners (PAs/NPs) which are not commonplace in radiology practice. The definitions of the service period times are equally confusing: the qualifier "non-surgical services such as E/M or non-surgical procedures" would confuse any radiologist.

The survey instrument includes a question regarding "medically related activities." We find this question confusing and misleading. A further qualifier directs the survey respondent “Don't include time spent on call.” It is not clear to the ACR why such information or questions about a bonus plan, are that relevant.
The survey instrument is clearly not directed towards imaging related services. Thus, we question whether any radiologist was involved in the drafting of the survey instrument. Given the shortcomings we described in our initial comment letter and the even more specific comments we provide here, we are concerned that the outcome of this validation exercise will itself be invalid.

**Potentially Misvalued Codes**

**Ultrasound Guidance**

CMS has indicated a number of codes as potentially misvalued based on Contractor Medical Director (CMD) input. The list includes CPT code 76942 (Ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection, localization device), imaging supervision and interpretation), and we use this as an example of potential shortcomings in using anecdotal CMD input to guide policy. 76942 was identified as a potentially misvalued code because of a CMD’s 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 stated that the CMD raised concerns “because of the high frequency with which it is billed with CPT code 20610 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.

The ACR thanks CMS for removing CPT code 76936 (Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging) from the list of additional potentially misvalued ultrasound guidance codes as it is not a code generally billed with an accompanying surgical code.
The ACR has no reason to believe that imaging guidance code 76940 is misvalued but have expressed our willingness to present survey data to the RUC to confirm that the value is appropriate.

In addition, CMS proposed several ultrasound guidance codes as potentially misvalued. The ACR supports the recommendation from the American Society for Radiation Oncology (ASTRO) that CPT Code 76965 be removed from the list of potentially misvalued ultrasound guidance codes. CPT code 76965 is most commonly billed with CPT codes 77787 (71%) and 55875 (62%). The physician time for CPT code 76965 is 62 minutes. The physician time for CPT code 77787 is 90 minutes and CPT code 55875 is 90 minutes. There is no discrepancy in procedure times and, therefore, no issue of ‘potentially inaccurate payments’. ASTRO also noted that CPT code 76950 will be deleted in 2015.

**Practice Expense Issues**

**Ultrasound Room Equipment Recommendations (General)**

In the proposed rule, CMS sought comment on the items included in the ultrasound room packages as compared to items included in other equipment rooms.

In the Final Rule, CMS states:

“…We remain concerned about the appropriate estimate of resources regarding equipment items, especially those in room packages. We note that in our previous statements regarding allocation of equipment minutes, we have articulated that equipment minutes should be allocated to particular items when those items are unavailable for use with another patient ‘due to its use during the procedure in question.’”

CMS further states that “…changes to particular equipment room packages should be made in the context of a broader examination of all equipment packages, as well as assumed equipment utilization rates for these packages.”

The ACR disagrees with CMS’ assertion that equipment rooms should be developed for particular procedures. Equipment rooms may be used for more than one type of procedure and even within one procedure, different equipment in the room may be used based on the complexity of the patient. CMS should recognize that the equipment items in an equipment room, even ones not immediately necessary, still cannot be used for another patient during a procedure. The CMS policy should read:
“Equipment packages called rooms should include all items that are typically in the room and cannot be used for another patient, in order to furnish all typical services performed in that room.”

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. Typically, 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.

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. Again, the ACR cautions against using broad public information such as newspaper articles as a basis of comparison for the pricing information submitted through the RUC process. The ACR continues to work 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**

In the proposed rule, CMS indicated 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 (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation) and proposed 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 ACR is extremely disappointed that CMS finalized the proposed adjustment of the clinical labor minutes associated 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 cleaning the equipment after the procedure. 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, another longstanding convention.

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

Since 2001, Medicare has used HCPCS G-codes, in addition to the CPT codes, for stereotactic radiosurgery (SRS) to distinguish robotic and non-robotic methods of delivery. CMS believes that it is no longer necessary to continue to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes.

Two of the four current SRS G-codes are paid in the non-facility setting through the MPFS. These two codes, G0339 and G0340, describe robotic SRS treatment delivery and are carrier priced. CPT codes 77372 and 77373, which describe SRS treatment delivery without regard to the method of delivery, are currently paid in the non-facility setting based on resource-based RVUs developed through the standard PE methodology.

CMS did not propose to replace the contractor-priced G-codes for MPFS payment but did seek comment from the public and stakeholders, including the AMA RUC, regarding whether or not the direct PE inputs for CPT codes 77372 and 77373 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 responded to the CMS’ request for information on the direct PE inputs for CPT codes 77372 and 77373. All SRS and stereotactic body radiation therapy (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 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. The ACR recommends that CMS replace the carrier priced G-codes for stereotactic radiation therapy with the existing CPT codes.

**Brachytherapy Services (77785-77787) Experiencing Unsustainable Reductions**

Brachytherapy is a form of radiation therapy where a radiation source is placed inside or next to the area requiring treatment. It offers convenient and cost-effective treatment for many Medicare patients. Brachytherapy is also associated with a low risk of serious adverse side effects. As the chart below illustrates, several brachytherapy services are slated for drastic reductions in for CY 2014.
The implementation of three new high dose rate (HDR) brachytherapy procedures codes in 2009 (i.e., 77785, 77786, 77787), corrections to HDR brachytherapy direct practice expense inputs for 2010, and utilization of the PPIS data has resulted in significant reductions to HDR brachytherapy reimbursement to freestanding cancer centers beginning in 2009. The ACR is very concerned that these cuts fail to reflect the costs of providing these services in the community setting and will jeopardize patient access to these services. We have heard from many brachytherapy sub-specialists and other members that they will no longer be able to provide these services or will be forced to severely limit these services going forward under these lower payment rates. Brachytherapy offers cost-effective care to Medicare beneficiaries. Continued cuts to its reimbursement, however, jeopardize this important subspecialty. The ACR urges CMS to reconsider these significant cuts.

Reconsider RUC Recommendations

Practice expense inputs for the HDR codes 77785-77787 were recently reviewed at the RUC. The agency’s decisions on these recommendations were announced in the 2014 final MPFS; listed in Table 29 of the regulations. The ACR was disappointed that the agency rejected many of the recommendations from the RUC. These recommendations were based on surveyed data and vigorously vetted by the RUC.

In particular, we object to the agency’s rejection of the “emergency service container-safety kit” on the list of equipment and categorization of the kit as an indirect practice expense. We strongly urge CMS to reconsider this decision, as by the standards used by CMS; this item is clearly a direct practice expense input.

The emergency container is a safety device used when a source must be retrieved manually. It is mobile and must be in the treatment room during source exchange. The service cannot be performed unless it is in the room. Direct practice expense inputs are
those costs directly assumed by a physician in the course of providing the service. These include the costs of medical supplies, staff time, and equipment. Indirect practice expense inputs measure the costs a practice incurs, such as the cost of labor, rent, office supplies, insurance etc. The description of the emergency container clearly puts it into the category of a direct practice expense input. **The ACR requests CMS to reconsider its decision and reclassify this item as a direct practice expense input.**

CMS also reduced time from the RUC recommendations for several direct inputs for the HDR codes 77785-77787. The refinements resulted in reductions from the RUC recommended times and can be found on pages 74370-74372 in the display copy of the final regulations. The ACR was very disappointed that the agency did not accept the RUC recommendations. These inputs were carefully vetted at the RUC; the process of care was reviewed, steps were taken to ensure that there were no overlaps in time and to confirm that allotted time followed RUC methodology. **The ACR requests CMS to accept the RUC direct input recommendations for HDR codes 77785-77787.**

**Invoice Pricing**

The ACR has worked with CMS and the RUC to supply documentation/copies of paid invoices in order to price CMS supplies and equipment. These invoices are distributed to all the RUC meeting participants and included as public information on the CMS site. Specialty societies have expressed concern in the past with CMS and the RUC regarding the current collection process.

CMS stated in the Final Rule “**We believe it is likely that the pricing information would be less market sensitive if the information served to confirm the assumptions we already display in the direct PE input database.**” That statement implies that specialty societies are not submitting pricing information because it is lower than the CMS prices, included in the direct PE database. That is **not** the case. Stakeholders in the marketplace are often able to identify the practice through this process, which has major implications to price negotiations and service lines in local markets.

The ACR strongly encourages CMS to work with specialty societies and the RUC to establish an acceptable process for this data collection and better protect this confidential information.

**Changes to Direct PE Inputs for Specific Services**

**Anomalous Supply Inputs**

CMS is removing six items from the direct PE input database from CY 2014 – including SK107 “fee, usage, cyclotron/accelerator, gammaknife, Linac SRS System” included in
CPT codes 77423 and 77422, because they do not consider them as disposable supplies. CMS believes these items are more appropriately categorized as indirect PE inputs. The ACR believes this expense should be included in the equipment direct expense category with the appropriate minutes associated with each code 77422/51 minutes and 77423/71 minutes. This fee relates directly to these procedures/equipment and is not an indirect expense.

Upon review of this issue, we have identified that equipment is missing in the RVS system and the laser targeting system – both were on the original recommendations. The original CMS code for the RVS system was E51022. The laser targeting system code is ER040. These two equipment items should be added back into both CPT codes and the appropriate minutes associated with each code 77422/51 minutes and 77423/71 minutes.

**Finalizing CY 2013 Work RVUs**

**Refinement Panel Review**

The ACR thanks CMS for increasing the work RVUs for CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) to the AMA RUC-recommended value of 6.60, from the interim value of 5.75 and the work RVUs for CPT code 35476 (Transluminal balloon angioplasty, percutaneous; venous) from 4.71 to 5.10 as recommended by the ACR, the Renal Physicians Association, Society for Vascular Surgery and Society of Interventional Radiology.

**CT Angiography (CPT code 72191)**

CMS indicated in the final rule that the interim work value for CPT code 72191 (Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image post-processing) will be maintained for CY 2014 to allow for public comment as per a recommendation by the AMA RUC. The ACR presented recommendations to the RUC in October of 2013 which included 72191 along with the other 2 codes in the visceral CTA family: 74174 and 74175. We are optimistic these recommendations will lead to CMS finalizing the values for this family.

**Radiologic Guidance: Fluoroscopic Guidance (CPT codes 77001, 77002, and 77003)**

In the CY 2014 Final Rule, CMS requests “additional public comment and input from the AMA RUC and other stakeholders regarding the relationship between the intra-service time associated with fluoroscopic guidance and the intra-service time of the procedure codes with which they are typically billed.” CMS expresses concern that the “recommended intra-service times for all three codes are generally higher than the procedure codes with which they are typically billed.”
The three fluoroscopic guidance codes being discussed are the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>2014 work RVU</th>
<th>Pre</th>
<th>Intra</th>
<th>Post</th>
<th>Total time</th>
<th>Global</th>
<th>RUC Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>77001</td>
<td>Fluoroguide for vein device</td>
<td>0.38</td>
<td>9</td>
<td>4</td>
<td>13</td>
<td>ZZZ</td>
<td>Apr 2013</td>
<td></td>
</tr>
<tr>
<td>77002</td>
<td>Needle localization by xray</td>
<td>0.54</td>
<td>7</td>
<td>15</td>
<td>5</td>
<td>27</td>
<td>XXX</td>
<td>Apr 2013</td>
</tr>
<tr>
<td>77003</td>
<td>Fluoroguide for spine inject</td>
<td>0.60</td>
<td>7</td>
<td>15</td>
<td>5</td>
<td>27</td>
<td>XXX</td>
<td>Jan 2012</td>
</tr>
</tbody>
</table>

CMS provides the following code combination as an example to substantiate their concern: 77002 and 20610.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>2014 work RVU</th>
<th>Pre</th>
<th>Intra</th>
<th>Post</th>
<th>Total time</th>
<th>Global</th>
<th>RUC Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>77002</td>
<td>Needle localization by xray</td>
<td>0.54</td>
<td>7</td>
<td>15</td>
<td>5</td>
<td>27</td>
<td>XXX</td>
<td>Apr 2013</td>
</tr>
<tr>
<td>20610</td>
<td>Drain/inject joint/bursa</td>
<td>0.79</td>
<td>11</td>
<td>5</td>
<td>5</td>
<td>21</td>
<td>XXX</td>
<td>Oct 2010</td>
</tr>
</tbody>
</table>

The ACR believes CMS’ concern is unfounded based on the following:

**Services typically reported together:**

CMS states that “the recommended intra-service times for all three codes are generally higher than the procedure codes with which they are typically billed.” In actuality, there are only two code combinations in the entire 5% file wherein one of the fluoroscopic guidance codes is typically reported (i.e. – greater than 50% of the time) with a surgical code in which the intra-service time of the guidance code is higher than the surgical code: 20610 / 77002 and 62311 / 77003.

In regards to the first combination 20610 / 77002, this combination involves a 0-day global surgical code with only 5 minutes of intra-service time, a time that is among the lowest time of any surgical code in the database and possibly an outlier. Additionally, code 20610 has a significant amount of physician work done during the pre-service, as is evident in the 11 minutes of pre-service time that is necessary, in addition to an evaluation and management service, because the physician is discussing possible complications and obtaining consent, prepping the joint for the injection and waiting for the local anesthesia to take effect.

The other combination is 62311 (intra – 10 min) and 77003 (intra – 15 min). Code 62311 is a 0-day global code recently reviewed by the specialty societies and the AMA RUC, however, the current work RVU for 62311 is interim final, and may undergo additional
refinement, thus, we discourage the use of the 62311 / 77003 combination as an example in this case.

We request that CMS provide additional examples to support its concern that the “recommended intra-service times for all three codes are generally higher than the procedures codes with which they are typically billed”, other than the two code combinations cited above before making adjustments to the intra-service times and work RVUs.

77001 is an add-on code:

Code 77001 is an add-on code and, consistent with the definition of an add-on code, describes only the physician work of fluoroscopic guidance that is performed in addition to the work of the primary code with which it is reported.

77002 and 77003 are essentially add-on codes:

Codes 77002 and 77003 describe physician work that is separate from and performed in addition to the physician work associated with the primary code. As such, the intra-service time of the primary code does not include the additional physician time associated with performing imaging guidance.

The survey process:

The aforementioned fluoroscopic guidance codes were recently surveyed and the respective survey instruments were carefully constructed to indicate that the respondent should only indicate work and time associated with the imaging guidance aspects of the service in question. For example, the typical patient description for 77002 described imaging guidance for a hip joint aspiration and clearly states “needle aspiration is reported separately.”

Further, the work descriptors only include activities specific to image guidance. The intra-service descriptor for 77002 is given below (note that all of the activities are imaging guidance specific and performed in addition to the base surgical activities).

*The patient is placed on an X-ray table and positioned appropriately depending on the type of procedure to be performed. Preliminary fluoroscopy is performed to identify the appropriate level and approach for the initial needle placement, and the skin entry site is prepped and marked. Sterile drapes are applied. During the needle placement, intermittent fluoroscopy is used to confirm the correct approach and the need for needle repositioning or realignment. When the needle position appears correct, radiographic contrast may be injected to confirm the proper position or tissue samples may be*
acquired and reviewed. If the position is not correct, additional fluoroscopy is utilized to guide repositioning until the proper position is achieved.

Component Coding Conventions:

Component coding for interventional procedures has been in existence since the early 90s, as described in the June 5, 1991 Federal Register (Medicare Physician Fee Schedule Proposed Rule, pg. 25806) which directs that carriers “pay for the radiological aspect of interventional procedures as described by supervision and interpretation (S&I) CPT codes and the primary non-radiological procedure code such as a surgical code at the full fee schedule amounts.” This language was accepted into the Final Rule as documented in the Federal Register November 25, 1991.

We are not aware of language in the interim directing carriers to abandon the conventions of component coding or for CMS to abandon a system they themselves championed over “complete procedure” coding which preceded the component coding system. When these component codes were valued by the RUC, care was taken to differentiate the physician work and practice expense activities for the S&I codes and the surgical codes so no duplication in work and practice expense RVUs occurred.

The ACR stands by the surveys performed for the three fluoroscopic guidance codes for the reasons espoused above, the quality of our physician surveys, and the established coding conventions inherent to these codes. The ACR urges CMS to finalize the work RVU of 0.54 for CPT Code 77002, the work RVU of 0.60 for CPT Code 77003 and the current work RVU of 0.38 for code 77001.

Cardiovascular System: Arteries and Veins (CPT codes 36221-36227)

In our CY 2013 Final Rule comment letter, the ACR and several other specialty societies recommended a refinement panel for CPT codes 36221 to 36227. CMS determined that the criteria for the request for refinement were not met and, as a result, they did not refer the codes to the CY 2013 Multi-Specialty Refinement Panel for further review. CMS maintains that the recommended direct crosswalks for these services are appropriate because the codes involve similar work. Therefore, they are finalizing the CY 2013 interim final values for CY 2014 for CPT codes 36221-36227. They are also finalizing the post-service time refinement of 30 minutes to CPT codes 36221-36226 for CY 2014.

As outlined in our 2013 Final Rule comment letter, CMS rejected the RUC recommended values for CPT Codes 36221 to 36227 with no significant or relevant discussion in the Final Rule. The brief and vague language in the Federal Register does not justify the apparent random values assigned to these CPT codes. The ACR again requests that this family be sent to a refinement panel for further discussion and that the values are
Finalizing CY 2013 Practice Expense RVUs

Diagnostic Radiology: Abdomen and Pelvis

In the Final Rule, CMS states:

In establishing interim final direct PE inputs for CY 2013, CMS reviewed the direct PE inputs for all of the abdomen, pelvis, and abdomen/pelvis combined CT codes. For each set of codes, CMS established a common set of disposable supplies and medical equipment. CMS established clinical labor minutes that reflect the fundamental assumption that the component codes should include a base number of minutes for particular tasks, and that the number of minutes in the combined codes should reflect efficiencies that occur when the regions are examined together. Among other refinements, CMS adjusted the intraservice time for CPT codes 72194, 74160, and 74177 by 2 minutes, 4 minutes, and 6 minutes respectively.

CMS refined the minutes in the service period such that the aggregate number of clinical labor minutes reflected in the direct PE input database and used to develop PE RVUs was consistent within this family of codes. CMS believes that the aggregate clinical labor time in each clinical service period (preservice period, service period, and postservice period) or aggregate number of minutes for particular equipment items that reflects the total typical resource use is more important than the minutes associated with each clinical labor task, which are a tool used by the AMA RUC to develop their recommendations. CMS hopes that in reviewing future services, commenters consider the aggregate clinical labor time as well, recognizing that it is the aggregate time that ultimately has implications for payment. CMS welcomes comments that address the appropriateness of the number of clinical labor minutes in each service period and the number of equipment minutes for each service.

The ACR agrees that the clinical staff, supplies and equipment should be consistent within a family of codes. The ACR also recognizes that bundled codes may yield efficiencies for certain staff activities. We remind CMS to recognize that the CT codes, 72194, 74160 and 74177 are all part of larger families with separate codes to describe “without contrast”, “with contrast” and “with and without contrast”. Each of these codes requires additional and often additive staff time, supplies and equipment times. The ACR remains concerned with the unilateral reductions in intra-service time made for 72194 and 74160 since these are base codes from which the combined CT A/P codes had their intra-service times derived.
The ACR appreciates that the aggregate minutes also should be consistent across families but we do not believe this should supersede a careful clinical based review of individual clinical tasks associated with each code with comparison to the existing Practice Expense Advisory Committee (PEAC) surveyed values. The ACR believes these types of determinations should be made through the RUC PE Subcommittee along with the clinical expertise and exchange which the PE subcommittee allows.

**Radiation Oncology: Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services**

CMS removed the equipment item “computer system, record and verify” from CPT Code 77301 and adjusted equipment time for “treatment planning system, intensity-modulated radiation therapy (IMRT) (Corvus w-Peregrine 3D Monte Carlo)” from 376 to 330 minutes. CMS argued that the computer system was not previously an input for this service and there was not sufficient information or evidence for them to conclude that there should be a change. The ASTRO made a detailed presentation at the RUC on both these topics, the inclusion of the record and verify system and the computation of the minutes included on the treatment planning system.

The treatment planning system is used for 376 minutes, which includes time for the physician, physicist and dosimetrist to do the following tasks on the system - image correlation and manipulation, contouring, planning and verification. In the Final Rule, CMS argued that the time the physician spends on the treatment planning system “is not appropriately placed on the technical component”. The physician spends significant independent time, not with clinical staff, at the treatment planning computer. The physician time on the machine must be included in the payment for CPT Code 77301. If CMS does not feel it is appropriate to include it in the 77301 TC it must adjust the methodology to include it in the 77301 global and 77301 professional component (PC).

CMS argued that the computer system was not previously an input for this service and therefore would not be included for CY 2014. The specialties made a detailed presentation at the RUC, which was accepted, as to why the record and verify system was needed. The record and verify system is computer software that checks the position of the couch, collimator, gantry and any beam modifiers before a treatment is given. The work on the record and verify system is an essential part of the IMRT planning process.

CMS is finalizing the CY 2013 interim final direct PE inputs for CPT code 77301 as established. This change is not appropriate and the ACR urges CMS to add the record and verify back in to the direct practice expense inputs for this code and re-adjust the times for the treatment planning system back to 376 minutes. The update should be retroactive back to January 1, 2014.
**Nuclear Medicine: Diagnostic**

The ACR disagrees with the CMS decision to discard invoices for single-photon emission computed tomography (SPECT)/CT equipment simply because they do not have the line item detail for items they do not consider equipment. Rather CMS should work closely with the societies that submitted invoices to utilize all available invoices for obtaining an average cost, backing out any minimal soft or questionable costs by discussing directly with the society staff. CMS’ choice to select only the lowest cost invoice is not representative of the true costs of the SPECT/CT equipment and therefore is undervaluing the cost of this service. The Society of Nuclear Medicine and Molecular Imaging (SNMMI) and ACR request a call or meeting to discuss a way to allow CMS to be able to utilize all invoices submitted for a balanced equipment cost.

**Establishing CY 2014 Interim Final RVUs**

We have attached a spreadsheet, which includes the ACR comments on CMS’ refinement of RUC recommended practice expense direct inputs.

**General Overall Comments**

The ACR is extremely concerned by the significant payment reductions for image-guided breast biopsy procedures, as well as for certain CT and MR services. Radiology services have had more codes identified as “potentially misvalued” than any other specialty. The ACR believes this is a result of inherent biases within the screening process for misvalued codes. There is tremendous variability in the way radiology services are delivered on a patient-by-patient basis. A granular coding system allows radiologists to very specifically describe the components that make up the entire service provided to a specific patient during an episode of care. This has resulted in numerous combinations of services that are appropriately reported together, but are then caught by the “reported together” screen. Although the bias may not have been created by design, it does exist. CMS’ unfounded payment reductions will punish radiologists for having created an accurate and well-established coding system.

Radiology has endured significant payment reductions as a result of a host of statutory and CMS policy changes under the MPFS. We are concerned with the negative impact that the policies may have on Medicare beneficiaries’ access to high quality outpatient imaging care. An illustrative example is the MR of the brain code (70551). In 2007, the TC payment rate for the brain MR code was $466.90. The TC payment rate for this same code in 2014 will be less than $200 and less than $100 if the patient has a prior study the same day and the MPPR is applied. A payment of less than $100 for a study performed on a $1.6M piece of equipment is clearly too low and does not pay physicians for the costs they incur treating Medicare beneficiaries. To assuage the overall impact of these
severe cuts and ensure a smooth transition to a new system of physician payment, we recommend CMS consider implementing a dampening policy to mitigate the severity of these cumulative impacts. This policy should put a cap on the percent decrease any particular code may be subject to in a given year.

**General Practice Expense Comments**

**CMS reductions in MRI technologist time for 70551 (MR brain w/o) and 70553 (MR brain w/o & w/):** CMS lowered the time for “Assist physician in performing procedure” for both of these codes. For advanced imaging, this activity is the same as “Acquire images” and we strongly disagree with these reductions. For 70551 the time for this activity is reduced from 30 to 20 minutes. For 70553, the reduction is from 40 to 38 minutes. The existing times are PEAC surveyed times and the ACR has no reason to believe the time to acquire images has decreased since PEAC review. More likely, the time has increased as new protocols and clinical protocols have evolved. The justifying comment provided by CMS is “CMS clinical review.” The ACR requests further justification than simply “clinical review” for a change which leads to significant reductions in PE RVUs.

**Supplies for breast interventions requiring MR guidance:** CMS removed a number of supply items necessary to complete MR guided procedures. CMS indicates “CMS clinical review; functionality of items redundant with other direct PE inputs” as their justification. CMS, however, ignores the fact that MR guided procedures require supplies which are MR compatible. In other words, supplies which will not interact with the strong magnetic fields created by MR imaging. This is a critical patient, staff, and physician safety issue as non-MR compatible devices can become airborne and be potentially lethal weapons when exposed to the MR magnetic fields.

**Other staff activities for which CMS reduced time:** CMS unilaterally reduced the clinical staff time for a number of activities providing “CMS Clinical Review” as the only justification for the reduction. The specialty societies base our recommendations on clinical experience and also the PEAC surveyed existing times. We are mandated to provide justification for our recommendations and do so before the PE subcommittee with CMS officials in attendance. Therefore, it is surprising to see refinements of this sort made “after the fact” with no specific clinical rationale provided. While we realize that it is not typical to ask for refinement for changes made to PE inputs, the lack of clarity in how these changes were made means that we would request refinement for the following codes: 19281-19283, 19286, 70551-70553, 72142, 72146-72149, 72156-72158, 74174, and 75726.

**Contrast Imaging Package:** For a number of codes, CMS did not allow inclusion of the Contrast Imaging Package, which a PE Subcommittee workgroup worked diligently to
create. This omission leaves out a number of clinically necessary supplies for contrast enhanced studies. Once again, while we realize that it is not typical to ask for refinement for changes made to PE inputs, the lack of clarity in how these changes were made means that we would request refinement for the following codes: 72142, 74147, 72149, 72156, 72157, and 72158.

**General Breast Biopsy Comments**

A number of code combinations describing breast interventions were identified by the “reported together” Relativity Assessment Workgroup (RAW) screen and the entire family was restructured by the CPT Editorial Panel into a family of 14 codes reflecting the entirety of breast interventions. The existing codes were deleted. The breast biopsy CPT codes 19102 and 19103, as well as preoperative placement of needle localization wire codes 19290 and 19291, image-guided placement of a localization clip code 19295, and guidance codes 77031 and 77032 were deleted in 2014. As of 2014, new codes 19281-19288 were established to describe the image-guided placement of localization devices without image-guided biopsy. Prior to 2014, there was no specific code to describe placement without the performance of a biopsy, therefore, the ACR recommended these codes be created.

The ACR is concerned that the resulting reductions in reimbursement for image-guided breast biopsy will turn the clock back on women’s health. Should minimally invasive biopsy techniques become less available, this could lead to more open surgical biopsies. Open procedures are much more costly and carry greater risk to the patient than image-guided biopsy. We are especially concerned about potential reductions in access for poor, rural and other underserved communities that may serve to further widen existing racial differentials in breast cancer mortality.

The specialty societies and the RUC did their best to appropriately value these services but there were a number of process challenges along the way which may have led to lower than appropriate values. For example, the sheer size of the family made achieving sufficient numbers of survey respondents difficult. Within that survey population, we also lacked adequate comparison codes since the spectrum of 0-day global services provided by those physicians was captured by the new code family. We appreciate that CMS accepted almost all of the RUC’s recommendations for the breast biopsy codes except for codes 19287 and 19288. Even so, we are requesting refinement for the entire code set. We hope that CMS recognizes that our request for refinement despite CMS' acceptance of the RUC recommended values for most of the breast biopsy codes emanates from a significant concern about potential reductions in access for the most vulnerable Medicare beneficiaries. The values recommended by the RUC simply do not recognize the value of these services. Practices that deliver these services have already faced multiple cuts to imaging in general. While we are confident that the radiology community will do its
utmost to preserve access, we are concerned that this may be the last straw for some practices already struggling to survive. To avoid a reversion to open surgical biopsies for the timely diagnosis of breast cancer, these values should be readdressed and increased. In summary, the ACR requests that this entire family (below) be referred to the Refinement Panel for reconsideration.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>RUC Approved work RVU</th>
<th>CMS Refined work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>19081</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance</td>
<td>3.29</td>
<td>3.29</td>
</tr>
<tr>
<td>19082</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure) (Use 191XX2 in conjunction with 191XX1)</td>
<td>1.65</td>
<td>1.65</td>
</tr>
<tr>
<td>19083</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance</td>
<td>3.10</td>
<td>3.10</td>
</tr>
<tr>
<td>19084</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure) (Use 191XX4 in conjunction with 191XX3)</td>
<td>1.55</td>
<td>1.55</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Value1</td>
<td>Value2</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>19085</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance</td>
<td>3.64</td>
<td>3.64</td>
</tr>
<tr>
<td>19086</td>
<td>Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)</td>
<td>1.82</td>
<td>1.82</td>
</tr>
<tr>
<td></td>
<td>(Use 191XX6 in conjunction with 191XX5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19281</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>19282</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>(Use 1929XX2 in conjunction with 1929XX1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19283</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>19284</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>(Use 1929XX4 in conjunction with 1929XX3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19285</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance</td>
<td>1.70</td>
<td>1.70</td>
</tr>
</tbody>
</table>

23
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Work RVU</th>
<th>Physician RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>19286</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure) (Use 1929XX6 in conjunction with 1929XX5)</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>19287</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance</td>
<td>3.02</td>
<td>2.55</td>
</tr>
<tr>
<td>19288</td>
<td>Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance, each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)</td>
<td>1.51</td>
<td>1.28</td>
</tr>
</tbody>
</table>

With specific regard to CPT codes 19287 and 19288, in the Final Rule, CMS indicates:

*We believe that the work RVU recommended by the AMA RUC for CPT code 19287 would create a rank order anomaly with other codes in the family. To avoid this anomaly, we are assigning a CY 2014 interim final work RVU of 2.55, which is between the 25th percentile and the median work RVU in the survey. In determining how to value this service, we examined the work RVU relationship among the breast biopsy codes as established by the AMA RUC and believed those to be correct. We used those relationships to establish the value for CPT code 19287. We believe that using this work value creates the appropriate relativity with other codes in the family. To value CPT code 19288, we followed the same procedure used by the AMA RUC in making its recommendation for the add-on codes, which was to value add-on services at 50 percent of the applicable base code value, resulting in a work RVU of 1.28 for CPT code 19288. We received public input suggesting that when one of these procedures is performed without mammography guidance, mammography is commonly performed afterwards to confirm appropriate placement. We seek public input as to whether or not post-procedure mammography is commonly furnished with breast biopsy and marker placement, and if so, whether the services should be bundled together. Finally, we note that the physician intra-service time for CPT code 19286, which is an add-on code, is 19 minutes, which is higher than the 15 minutes of intra-service time for its base code, CPT code 19285. Therefore we are reducing the intra-service time for CPT code 19286 to the survey 25th percentile value of 14 minutes.*
The ACR disagrees with CMS’ reasons for lowering the work RVU of these 2 codes. The recommendation of 3.02 for code 19287 and 1.51 for code 19288 are appropriate and maintain relativity across the breast intervention family. These 2 codes represent MR guided procedures and both of them have longer intra-service times than the other codes in the clip placement family: 37 and 30 minutes, respectively. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well. Regarding the decrease in time for code 19286 from 19 to 14 minutes, the ACR believes the intra-service time for code 19286 should be 15 minutes, the same as its base code and consistent with other base code / add-on codes across this family.

Our recommendation for code 19287 yields an IWPUT of 0.0585, reflecting the intensity of this procedure in this subset of patients. Indeed, the patient is laying prone with her breast in compression throughout the intra service period of this procedure. The MR table is inherently uncomfortable leading to frequent complaints of neck and shoulder pain during the procedure as time passes. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite tense. The images for the biopsy are performed on a biopsy device rather than a dedicated breast coil and, as such, correlating the lesion to be marked to the initial lesion of concern can be challenging especially for very small lesions which are typically the ones for which MRI has to be performed since they cannot be visualized sonographically. Many patients have feelings of claustrophobia even if they are actually able to tolerate the machine; this increases the anxiety level of the patient and the pressure on the physician, thus increasing the intensity of the procedure.

Regarding the post procedure mammogram, the ACR believes this is a separately reportable service requiring additional work and practice expense not captured by the codes in this family. It is inappropriate to bundle the post-procedure mammogram, which is commonly associated with these procedures.

The ACR urges CMS to accept the RUC recommendations of a work RVU of 3.02 for CPT code 19287 and 1.51 for CPT code 19288. In addition, the ACR requests that these codes be referred to the Refinement Panel for reconsideration along with the entire family of breast biopsy codes as described above.
Specific Comments on Work RVUs:

**Transcatheter Placement Intravascular Stent**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>RUC Rec Work RVU</th>
<th>CMS Proposed Interim work RVU</th>
<th>CMS Work RVU Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>37239</td>
<td>Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein; each additional vein (List separately in addition to code for primary procedure)</td>
<td>3.34</td>
<td>2.97</td>
<td>Disagree</td>
</tr>
</tbody>
</table>

CMS indicates:

*The AMA RUC recommended a work RVU of 3.34 for CPT code 37239, which they cross-walked to the work value of 35686 (Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)). CPT code 37239 is the add-on code to 37238 for placement of an intravascular stent in each additional vein. The AMA RUC valued placement of a stent in the initial artery (CPT code 37236) at 9.0 work RVUs and its corresponding add-on code (37237) for placement of a stent in an additional artery at 4.25 work RVUs. After review, we believe that the ratio of the work of placement of the initial stent and additional stents would be the same regardless of whether the stent is placed in an artery or a vein, and that the appropriate ratio is found in the AMA RUC-recommended work RVUs of CPT codes 37236 and 37237. To determine the work RVU for CPT code 37239, we applied that ratio to the AMA RUC-recommended work RVU of 6.29 for CPT code 37238. Therefore, we are assigning an interim final work RVU of 2.97 to CPT code 37239 for CY 2014.*

The ACR disagrees with CMS' methodology in lowering the work RVU of code 37239. It is inappropriate to assume the ratio of the arterial base stent code to the arterial add-on stent code would be the same as the ratio for the vein codes. Interventions in the arterial and venous system have different indications, technique, and physician work. Therefore, the survey times, comparison codes and clinical rationale provided by the specialty societies support the recommendation of 3.34 RVU. CMS mentions the key reference service (KRS) code of 35686. 37185 (mechanical thrombectomy) is another applicable
The ACR urges CMS to accept its original recommendation of 3.34 work RVUs for CPT code 37239. In addition, the ACR requests that this code be referred to the Refinement Panel for reconsideration.

**Embolization and Occlusion Procedures**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>RUC Work RVU</th>
<th>CMS Proposed Work RVU</th>
<th>CMS Work RVU Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>37242</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)</td>
<td>11.98</td>
<td>10.05</td>
<td>Disagree</td>
</tr>
<tr>
<td>37243</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction</td>
<td>14.00</td>
<td>11.99</td>
<td>Disagree</td>
</tr>
</tbody>
</table>

CMS indicates that for 37242:

*The AMA RUC recommended a direct crosswalk to CPT code 34833 (Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral) because of the similarity in intraservice time. The service described by CPT code 37242 was previously reported using CPT codes 37204 (Transcatheter occlusion or embolization (eg, for tumor*
destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck, 75894 (Transcatheter therapy, embolization, any method, radiological supervision and interpretation), and 75898 (Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis). The intraservice time for CPT code 37204 is 240 minutes and the work RVU is 18.11. The AMA RUC recommended intraservice time for CPT code 37242 is 100 minutes. We believe that the AMA RUC recommended work RVU does not adequately consider the substantial decrease in intraservice time for CPT code 37242 as compared to CPT code 37204. Therefore, we believe that the survey’s 25th percentile work RVU of 10.05 is consistent with the decreases in intraservice time and more appropriately reflects the work of this procedure.

CMS indicates that for 37243:

The AMA RUC stated that work RVU of CPT codes 37243 and 37244 should be the same despite a 30-minute intraservice time difference between the codes because the work of CPT code 37244 (recommended intraservice time of 90 minutes) was more intense than CPT code 37243 (recommended intraservice time of 120 minutes). This service was previously reported using CPT codes 37204, 75894 and 75898; or 37210 (Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyoma), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure). The current intraservice time for CPT code 37204 is 240 minutes and the work RVU is 18.11. The current intraservice time for CPT code 37210 is 90 minutes and the work RVU is 10.60. The AMA RUC-recommended intraservice time for 37243 is 120 minutes. We do not believe that the AMA RUC-recommended work RVU adequately considers the substantial decrease in intraservice time for CPT code 37243 as compared to CPT code 37204. We also note that the AMA recognized that CPT code 37243 is less intense than CPT code 37244. Therefore, we believe that the survey’s 25th percentile work RVU of 11.99 more appropriately reflects the work required to perform this service.

The ACR disagrees with CMS' rationale for decreasing the RUC recommendation for 37242 and 37243 based on the decrease in intra-service time between the existing code 37204 and the recommendations for the surveyed code. To our knowledge, 37204 has never been surveyed to RUC standards, exemplified by the indication in the RUC database: "DO NOT USE TO VALIDATE PHYSICIAN WORK" (Caps used in the RUC database, so reflected here also). In other words, comparing the recent survey time to a non-surveyed time is inappropriate. The specialty societies presented quality multi-specialty survey data, applicable comparison studies, and sound clinical rationale to justify our recommendation. **The ACR urges CMS to accept its original**
recommendation of 11.98 for CPT Code 37242 and 14.00 for CPT Code 37243. In addition, the ACR requests that these codes be referred to the Refinement Panel for reconsideration.

Multiple Procedure Payment Reduction

The ACR appreciates CMS not expanding the MPPR policies for imaging services for CY 2014 and considers this to be an appropriate decision. We continue to maintain that there are no efficiencies when multiple PC services are provided by the same physician or different physicians in the same group practice during the same session.

In 2011, the Journal of the American College of Radiology (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.

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 maintained that the MR scanner is 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 are be compounded by the 90 percent utilization rate in 2014.

QUALITY PROVISIONS

Physician Compare

CMS finalized plans for a phased approach for expanding public reporting of physician performance information on the Physician Compare website. CMS intends to publicly report in 2015 all measures collected through the Group Practice Reporting Option (GPRO) web interface for groups of all sizes participating in the 2014 PQRS GPRO, and for ACOs participating in the Medicare Shared Savings Program (MSSP). CMS also finalized its proposal to publicly report, as early as 2014, certain measures that groups report via registries and electronic health records under the PQRS GPRO. CMS has stated that it will provide for preview of data and correction prior to publication.

The ACR appreciates CMS’ intention to expand Physician Compare in a phased approach. We believe that a methodical implementation of measures for which performance information is reported should allow for thoughtful consideration on how the performance information is presented. Considering that a broad spectrum of individual patients may view the data, it is important to ensure understanding of the measure focus across patient groups. This will avoid misleading or potentially alarming patients unnecessarily about the quality of their physician’s care.

Physician Quality Reporting System (PQRS)

By statute, 2014 is the last year in which a PQRS incentive (0.5 percent) may be obtained. Additionally, 2014 PQRS reporting determines assessment of a payment adjustment (-2.0 percent) in 2016.
CMS finalized the following changes to PQRS for 2014:

- Increase in the number of measures that must be reported from three to nine measures for incentive purposes. The measures must cover at least three of the National Quality Strategy (NQS) domains. Subject to measure applicability validation, less than nine measures/three domains may be reported if less than nine measures/three domains apply to the practice. Additionally, one measures group may be reported satisfactorily to meet incentive requirements.
- Reporting rate requirement for registries was reduced to 50% of relevant cases vs previous 80% requirement.
- Physicians may report on ONLY three measures on 50 percent of their applicable patients to avoid the 2016 PQRS penalty; reporting one measures group will also avoid the payment adjustment.
- Eliminated the six-month reporting period for 2014, with the exception of measures groups reporting.
- PQRS measures groups in 2014 will only be reportable through a registry.
- Group practices of 25 or more eligible professionals (EPs) using the Group Practice Reporting Option (GPRO) may count Clinician and Group Consumer Assessment of Healthcare Providers and Systems CG-CAHPS survey measures (via certified survey vendor) as three measures towards the required nine.
- Added use of qualified clinical data registry (QCDR) as a mechanism for satisfactory PQRS participation for individual EPs only. EPs must report nine measures across three NQS domains and at least one outcomes measure for 50% of relevant cases to be incentive eligible. To avoid the payment adjustment, EPs must report at least three measures. QCDRs may offer both PQRS and non-PQRS measures for reporting.

*Increase in Measure Reporting Requirements*

CMS had proposed to allow EPs to be incentive eligible/avoid penalty if reporting less than nine measures when only 1-8 are relevant to their services, but only with claims-based reporting. CMS finalized this for claims reporting, but also allows for reporting less than nine measures when using a traditional registry, subject to measure validation. CMS also allows reporting only three measures, for purposes of avoiding the payment adjustment, when an EP participates in PQRS using a QCDR.

The ACR appreciates CMS’ recognition that many specialists, including radiologists, do not have nine measures to report, and so allows processes for both EPs to report the applicable measures that they can, using either claims-based or registry reporting and still obtain an incentive. We ask that CMS continue to maintain this process and choice until such time that a substantial majority of physicians have the ability to fully meet reporting requirements.
Reporting using a QCDR

The new QCDR option offers hope for providing physicians with meaningful and potentially plentiful reporting and measurement opportunities. Although somewhat disappointed that CMS is maintaining the steep requirement of reporting nine measures (one outcome) across three NQS domains, the ACR is pleased that CMS is allowing EPs using a QCDR to report only three measures for purposes of avoiding the PQRS payment adjustment. In the initial year of this option, even currently existing, robust clinical data registries with a library of nine or more measures may not provide many sub-specialists with nine measures in the QCDR. Although QCDRs stand to expand reporting opportunities, it will be several years before a substantial number of EPs will benefit from emerging QCDRs.

Reporting exemption

While CMS has allowed a process for EPs or groups to report less than the increased requirement of nine measures, subject to validation of reporting opportunities, it has not clearly defined a process for EPs who do not have any measures to report to avoid the PQRS payment adjustment. For the 2013 PQRS reporting year/2015 PQRS penalty year, the Administrative Claims-based option allowed a reporting exemption whereby an EP could elect the Administrative option to avoid the 2015 penalty. In educational materials following the 2014 Final Rule publication, CMS mentioned that an EP who did not report any measures would undergo a claims analysis to determine if measures could have been reported, and recommended that such EPs contact the QualityNet Help Desk to confirm that no measures are reportable. This does not sufficiently define the process for an EP to pursue an “exemption” from the PQRS payment adjustment. The **ACR urges CMS to formalize an exemption process for EPs who cannot report any measures in 2014 and beyond.** There should be some way that individual EPs or groups can indicate to CMS that they are not reporting because they have no measures to report, subject to validation, so that they are not considered “non-PQRS reporters” subject to the -2.0% PQRS penalty and the -2.0% VM penalty. Since measures may be available in the future that the EP/group can report, the exemption request by the EP/group may need to occur annually even if in the prior year the EP/group earned an exemption.

Measures group reporting

CMS finalized its proposal to not allow claims based reporting of a measures group. Thus, the only way to report a measures group in 2014 is through a registry. It seems unreasonable to require EPs to incur the expense of using a registry in order to report on a 20-patient sample. CMS states that an EP may choose to report individual quality measures with claims at no cost vs. using a registry for measures groups. This is
assuming that an EP has individual measures to report. The ACR asks that CMS consider reinstating the option to report measures groups with claims.

PQRS measures groups that were implemented prior to 2014 included measures within the measures group that were also reportable as individual claims based measures. This allowed an EP to report a measure separately or as part of a measures group (specifications may differ slightly). Most of the newly finalized measures groups, including the Optimizing Patient Exposure to Ionizing Radiation (OPEIR) measures group are only reportable as a group, not as individual measures. As a co-developer of the OPEIR set, the ACR is pleased that these measures are in 2014 PQRS. However, we reiterate our comment from the proposed rule urging CMS to allow reporting of the OPEIR measures as individual measures in future years. While the six OPEIR measures do basically have the same denominator, typical of a measures group, what makes the denominators similar is the type of imaging exam (CT) and not the patient condition or care process, as is true for most other measures groups. The OPEIR measures’ focus is optimizing exposure to radiation but the approach to doing so with each measure distinctly varies, and each measure requires implementation of a separate process or mechanism. Thus, it may be very unlikely that a radiology practice can accomplish all six of the measures in one year, particularly the first year.

Issues with GPRO reporting

CMS finalized several proposals related to the GPRO, including increased reporting criteria that mirrors the 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. However, two major options that highly benefit EPs are not available to GPROs, limiting reporting choices for GPROs and limiting the number of group practices that may self-nominate to be GPROs: 1) CMS does not allow GPROs to report measures groups; and 2) to participate in a QCDR for PQRS satisfactory participation.

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 groups to participate. The ACR finds the discrepancy between requirements for individual EPs and GPROs confounding. Some measures groups may make more sense at the group level. This is particularly true with the OPEIR measures group since the OPEIR measures are structural in nature, and the necessary technology and system enhancements will likely be done at a group level and in many situations in conjunction with a facility. Therefore, 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 an individual radiologists may work together with their groups or facilities to implement technology would be a better solution.**

GPROs cannot use a QCDR for PQRS. The ACR sees a need and use case for groups to participate in quality improvement activities using a clinical data registry. Some measure performance rates may be more statistically accurate at a group level due to denominator size. And as mentioned above, certain measures more inherently lend themselves to group or facility level participation. **We urge CMS to enable GPROs to participate in PQRS using QCDRs in the future. If it is not statutorily possible at this point, we ask that CMS seek legislative change to allow such use.**

Some group practices may wish to use the GPRO because many individual EPs in the group have no measures to report, and reporting as a GPRO would prevent those EPs with no measures from having a payment adjustment. The same group may wish to report a measures group or use a QCDR for the most relevant and useful measurement, particularly in considering how they may fare under the Value Modifier quality tiering; these EPs would have to report as individuals in order to enable this evaluation. Thus, these EPs must determine which choice is the most beneficial to them, whereas if the same reporting options as a GPRO were available – the decision would be simpler. **The ACR suggests that CMS consider another option - extend the 50% group threshold option for purposes of avoiding the Value Modifier penalty to the PQRS program, so that a group in which 50% of the members report PQRS measures avoids the PQRS and VM penalty.**

**Qualified Clinical Data Registry (QCDR)**

CMS finalized 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.

The ACR is pleased with the approach CMS has finalized for implementing the clinical data registry option. We are hopeful that the newly authorized option will give physicians the opportunity to participate in quality improvement and measurement activities, while at the same time allowing them to avoid payment penalties or qualify for incentives. **We understand CMS limiting non-PQRS measures to 20 that a QCDR can report to CMS in the initial year, 2014, but we urge CMS to consider increasing that limit in**
While 20 measures would seem to enable full PQRS participation for many physicians, having available, relevant measures given physician subspecialization, is still an issue at that number.

CMS finalized its broad definition of an outcomes measure, that is, one that 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. The ACR appreciates CMS’ approach and is hopeful that such a measure may be reasonably designed for radiology and enable a radiology society-based clinical data registry to qualify.

**Future of PQRS**

**Claims reporting**

In the proposed rule, CMS asked whether it should eliminate the claims-based reporting option in 2017, as registry and EHR reporting become more widely used. The ACR strongly recommends that CMS maintain the claims reporting mechanism until a substantial majority (>90%) of eligible EPs begin utilizing another option. While we recognize the limitations that claims reporting places on measure constructs, the mechanism provides a low-cost, effective means of widespread reporting.

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

CMS did not finalize inclusion of several measures currently used in the Inpatient Quality Reporting (IQR) program in PQRS. In agreement with many commenters, CMS recognized operational and other issues with implementing the IQR measures and deferred their inclusion until 2015. The ACR appreciates CMS moving slowly and considering potential negative implications in using the measures.

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

CMS finalized numerous proposals for 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, based on 2014 PQRS reporting.
- Make quality-tiering mandatory for groups within Category I (PQRS reporters) 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, including the CG-CAHPS survey measures and QCDR measures.
- Include the Medicare Spending Per Beneficiary (MSPB) measure in the total per capita costs for all attributed beneficiaries domain of the cost composite, using the single group attribution of costs for group with plurality of Part B services for the entire episode (3 days prior and 30 days post hospitalization).
- Refine the cost measure benchmarking methodology to account for the physician specialties within a group.

**Group size**

CMS finalized application of the VM for groups of 10+ EPs in 2016 based on 2014 reporting. According to CMS calculations, this means the VM will affect about 60% of physicians billing under Part B. Additionally, CMS finalized quality-tiering (QT) for all groups participating satisfactorily in PQRS (Category 1 groups) for the 2016 VM. Groups of 10-99 will only be subject to an upward or neutral (0%) payment adjustment while groups of 100+ will also have payment at risk based on performance. Groups that do not participate satisfactorily in PQRS (Category 2) will have a -2.0% payment adjustment, an increase from -1.0% for 2015 payment adjustment.

As an alternative to GPRO reporting, CMS finalized an option whereby a group in which at least 50 percent of the EPs within the group report measures successfully to avoid the 2016 PQRS payment adjustment, would also be considered as “Category 1”, successful reporters. Category 1 avoids the VM payment adjustment, but is subject to quality tiering.

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 (presumably 2017, although this has not yet been specified). The ACR reiterates its position that 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. So, we recommend that groups of 10-99 only be potentially subject to -1.0 percent payment adjustment in 2017, their first penalty year, rather than an initial payment adjustment of -2.0 percent.
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 in 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. The ACR agrees that timely performance feedback is critically important, in that EPs need to know where they stand with adequate notice in order to modify practices, if appropriate, to improve measure rates upon which reimbursement factors will be tied. For truly effective feedback, performance and feedback should 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 change accordingly. However, some measurements with small sample populations might require a longer period of time to show any improvement. In these cases, a rolling 12 month cycle reported on a quarterly basis would be effective.

Cost Measures – Medicare Spending per Beneficiary Measure (MSPB)

CMS finalized using the MSPB measure in the VM cost composite beginning in CY 2016. CMS proposed including the MSPB measure using multiple group attribution to any group providing Part B services to a patient with an acute hospitalization. Using that attribution method, the measure could potentially be attributed to radiology practices. This would be the only cost measure calculated for radiology groups. However, CMS finalized using the single group plurality of costs attribution, so it is highly unlikely to be attributed to a radiology group. This would default the cost composite score in the VM calculation to “average cost” for groups having no cost measures attributed/calculated (i.e. radiology groups), as finalized by CMS.

While the ACR tentatively supported use of the MSPB measure with an attribution method that would include radiology groups, we believe that CMS first needs more experience with the MSPB measure and its potential impact on physician services. At the same time, we recognize the need for inclusion of cost measures relevant to radiology practices and would like to continue working with CMS on development of such measures in the near future.
Conclusion

With the numerous, critical impacts to radiology reimbursement including the DRA, the statutory change in the equipment utilization rate, interest rate changes, changes in practice expense inputs, the PPIS and the MEI, the ACR once again 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. The ACR remains deeply concerned that these latest 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. The ACR believes that the 2014 payment policies resulting in significant payment cuts to radiology services once again will adversely affect patient access. 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 final 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 and radiation oncology. 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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Attachment