RBMA
Building the Business of Radiology

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August 31, 2007

Herb A. Kuhn
Deputy Administrator (Acting)
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: CMS-1385-P Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008

Dear Mr. Kuhn:

The Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the proposed rule for the 2008 Medicare physician fee schedule as published in the July 12, 2007 *Federal Register*.

Founded in 1968, the RBMA represents nearly 2,200 radiology practice managers and other radiology business professionals. In the aggregate, RBMA's reach extends to over 24,000 radiologic technologists and 26,000 administrative staff. RBMA is the leading professional organization for radiology business management, offering quality education, resources and solutions for its members and the healthcare community, and helping shape the profession's future.

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Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Discussion of Equipment Usage Percentage (Page 38132)

RBMA supports CMS' proposal to maintain the 50 percent utilization rate for medical equipment in the PERVU methodology until such time that it can be replaced by a comprehensive, multispecialty, modality-specific, and data-based estimate. Moreover, RBMA recommends that any new utilization rate be phased-in incrementally over a period of several years.

RBMA is concerned about potential future changes to the utilization rate for medical equipment in CMS' PE methodology. The utilization rate is a key variable in CMS' equipment cost per minute calculation. However, the utilization rate is difficult to estimate because of the following:

- Part-time vs. full-time centers – CMS' 150,000 minute/year figure assumes full-time operation (i.e., 50 hours/week * 50 weeks/year). This would be a significant overstatement for the vast majority of centers, particularly those in rural areas which are open only limited days during the week due to staffing limitations, physician availability, and patient volume.

- Missed appointments – missed patient appointments result in available machines being unutilized
- Modality – utilization rates typically vary by equipment type
- Site-of-service – utilization rates may vary by site-of-service (freestanding center, IDTF, mobile)
- Down-time for equipment maintenance – imaging equipment, particularly the high-technology CT, MR, and PET scanners, are routinely taken "off-line" for maintenance
- Down-time for equipment quality control/quality assurance – imaging equipment is routinely tested to ensure image quality while minimizing radiation (if applicable) exposure. Many radiology practices have their equipment accredited by the American College of Radiology (ACR) and other bodies who require this type of testing.
- Staffing issues – in light of today's shortage of radiologic technologists, absenteeism brought about by sickness, tardiness, etc. results in available machines being unutilized
- Specialty – utilization rates could vary by provider specialty
- Other – weather and power outages are examples of uncontrolled influences that reduce equipment productivity

RBMA also cautions CMS that the utilization rate could affect patient access to medical services in underserved areas. For example, rural settings are more likely to have their imaging needs met by part-time centers. A utilization rate based on high-volume centers could have unanticipated negative consequences on quality and access in these areas.

A change in utilization patterns is another potential consequence of adjusting the utilization rate. An increase in the utilization rate will likely result in a decrease in Medicare's technical component (TC) payments. State-of-the-art imaging equipment is a long-term investment and imaging centers, particularly those that are highly leveraged, may not be able to survive at the lower TC payment rates or may engage in activities aimed at increasing volume. Finally, lower TC payments may discourage investment in equipment.

For the abovementioned reasons, **RBMA recommends any significant change in the utilization rate be supported by empirical data and be phased-in incrementally over a period of several years.** For example, a shift to a 70 percent utilization rate would be implemented over four years -- 5 percent per year. This would cushion the financial impact on physician practices and freestanding facilities and could help mitigate potential operational and/or clinical disruptions caused by the change.

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Equipment Interest Rate Discussion (Page 38132)

RBMA agrees with CMS' decision in the proposed rule to retain the 11 percent interest rate used for PERVU determination.

Tying the PERVU interest rate to a moving estimate like the prime rate (alone or with an adjuster of 2 to 4 percent) adds unnecessary volatility to the Medicare fee schedule. This is an important factor, particularly for the purchase of imaging equipment, as these are typically long-term purchases. The prime rate is influenced by exogenous factors such as inflation, the availability of money, and the health of the economy – along with real and/or perceived perspectives of these factors by the financial markets. While the prime rate has been as low as 4 percent briefly in 2003, primes in the 8 percent to 9 percent range have been more common over time and since the inception of RBRVS in 1992. Further, the recent cuts to the TC payable under the MPFS have decreased the financial health of most non-hospital facilities, making them a greater credit risk and increasing the interest rates they must pay. Thus, the prime rate plus an adjustor of 2 to 4 percent, results in an

approximate rate at the current level of 11 percent. Additionally, with a prime-based methodology, CMS would have to determine when, in terms of timing, to base the prime rate – retroactively (i.e. a look-back) or prospectively (i.e. a forecast).

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PE Proposals for Calendar Year (CY) 2008 – Radiology Practice Expense Per Hour (Page 38132)

RBMA supports CMS' plans to use the revised practice expense per hour estimate for radiology ($204.86) rather than the current figure ($174.18).

RBMA commends CMS for its ongoing efforts in tailoring its methodology so that it better approximates radiology's practice expenses. Weighting radiology's practice expense data by practice size is an appropriate step in that direction.

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Geographic Practice Cost Indices (GPCI)

Physician Work (Page 38138)

RBMA favors retention of the work GPCI "floor" of 1.0.

The RBMA believes that retaining the work GPCI floor of 1.0 helps providers in rural areas. RBMA encourages CMS to use its authority to extend the GPCI floor into 2008 or to ask Congress for such authority.

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Malpractice

Malpractice (MP) RVUs (TC/PC Issue) (Page 38142)

The total technical component (TC) RVU should include malpractice values in addition to those for practice expense. The TC malpractice RVUs should be subjected to a resource-based evaluation.

In the proposed rule, CMS solicited information on the liability insurance carried by facilities. Radiology TC-providers (e.g., imaging centers) purchase umbrella malpractice liability policies that cover both the facility and its non-physician clinical personnel (e.g., radiologic technologists, nurses, physician assistants). Facilities also carry other (non-malpractice) forms of insurance (presumably falling under the practice expense RVUs). A facility's malpractice coverage is separate and distinct from a radiologist's professional liability insurance which is represented by the professional component (PC) malpractice RVUs.

The agency and the medical community continue to work on the "resource-based" nature of the RBRVS. The work relative values are based on physician time and intensity estimates and undergo a review every five years. Methodologies are in place and data collected for resource-based practice expense values. The physician's malpractice values are based on professional liability premiums. RBMA believes the TC's malpractice values should be resource-based as well and stands ready to assist CMS in this regard.

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Coding – Additional Codes from the Five-Year Review

Anesthesia (Page 38148)

RBMA encourages CMS to apply the budget neutrality adjustment from changes in anesthesiology's work values and other services in the Five-Year Review to the conversion factor rather than the work values.

Budget neutrality adjustments to the conversion factor rather than the relative values maintain the inter-procedural relativity of the RBRVS. It is also more readily apparent and understood by providers and their staff.

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Independent Diagnostic Testing Facility (IDTF) Issues

RBMA commends CMS' efforts to clarify the regulations governing IDTFs and improving the quality of care provided in these facilities.

Proposed Revisions to Existing IDTF Performance Standards – Comprehensive Liability Insurance (Page 38169)

RBMA is concerned that the proposed requirement wherein "the IDTF must list our [Medicare/CMS] designated contractor as a Certificate Holder on the [comprehensive liability insurance] policy" may prevent IDTFs from obtaining such insurance.

The proposed regulation may make it more difficult for IDTFs to obtain comprehensive liability insurance from underwriters due to concerns about indemnifying contractors of the federal government.

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Section 410.33(g) (8) -- Answer, document, and maintain documentation of beneficiaries' questions... (Page 38170)

RBMA believes the proposed requirements are overly burdensome and in excess of that required by other providers in the physician office or hospital facility settings.

Being responsive and empathetic to patient complaints, questions, and inquiries is part of delivering excellent customer service and patient care. All providers should have some mechanism in place for handling such situations and be required to produce such a policy/procedure upon request. CMS would only need to verify that such processes are in place. Therefore, the proposed regulations are unnecessary, not to mention ambiguous (e.g., what constitutes a complaint?) and labor intensive to implement.

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Section 410.33(i) – Enrollment date (Page 38170)

RBMA recommends that retroactive billing (once approval has been determined) be allowed back to the time of the original application (even if the first submission is rejected).

RBMA is supportive of the proposed change establishing the date the initial application is received as the date for which IDTFs may bill Medicare retroactively for services rendered. It is a concern of RBMA's that IDTF applications are experiencing significant contractor processing delays in many cases.

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Section 410.33(g) (15) – Shared space, equipment... (Page 38171)

RBMA supports the proposed prohibition on shared equipment but urges that this regulation be applied to all entities (including physician practices, mobile units, and hospitals) that provide imaging services.

RBMA believes that CMS is correct in being concerned about the potential for circumventing IDTF enrollment and Medicare billing requirements and the potential for abuse that may be caused by these sharing arrangements. Moreover, we suggest that this prohibition be extended to other sites of service given that the potential for abuse exists there as well.

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Physician Self-Referral Provisions

Anti-Markup Provision (Page 38179)

RBMA supports CMS' efforts to remove the "profit" from the reassignment of the professional or technical components from radiology services.

The potential for abuse and over-utilization exists if the billing (purchasing) physician or medical group is able to mark-up the interpretation or test when billing Medicare. RBMA, therefore, supports the proposed anti-markup provision and the expansion of the Purchased Diagnostic Test Rule to the professional component of imaging services. We also strongly support the elimination of the Stark "On the Premise" Interpretation requirement.

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Full-Time Employee Exemption (Page 38180)

RBMA views the full-time employee exemption as generally a step in the right direction, but recognizes that definitional and operational issues exist.

CMS is proposing to change section 414.50 so that, "the anti-markup provision for the technical component (TC) and professional component (PC) apply to all arrangements not involving a reassignment from a full-time employee of the billing entity." In other words, the anti-markup provision would apply to TC and PC reassignments from contractors and part-time employees. RBMA sees this provision as another safeguard against entities profiting from the TC or PC providers and, thus, is supportive of the concept. However, RBMA recognizes the need for CMS to work through some definitional and operational issues. Specifically, the proposed rule defines neither "part-time" nor "full-time" employee. Secondly, there is no distinction between a part-time employee versus a contract employee

of the practice. Without such definitions, confusion and the potential for abuse may result. One potential solution would be to modify the 855-R to state whether the physician is a full-time, part-time, or contract employee of the group. Another solution would be to exempt billing entities which are a radiologist or a radiology group from this requirement.

An alternative to an anti-markup approach would be to set a floor for the professional component. Such a floor (e.g., based on a percentage of the PC) and adjusted for bona fide collection costs, bad debt, etc. would have the same effect of prohibiting the profiting from the professional component.

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Unit-of-Service (Per-Click) Payments in Space and Equipment Leases (Page 38182)

RBMA strongly encourages CMS to move forward with its proposal to tighten the restrictions on per click imaging equipment lease payments as these types of arrangements encourage over-utilization of services and unnecessary self-referral.

Per-click arrangements of imaging equipment have been shown to lead to over-utilization and other forms of abuse. Percentage-based arrangements for space and imaging equipment leases also are prone to abuse and should also be eliminated. Lease arrangements featuring flat-rate payments which are not tied to volume are less susceptible to abuse.

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Ownership or Investment Interest in Retirement Plans (Page 38183)

RBMA agrees with the proposed elimination of the Stark Law exception that allows retirement plans owned by referring physicians to invest in Designated Health Services (DHS).

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"Set in Advance" and Percentage-Based Compensation Arrangements (Page 38184)

RBMA supports the elimination of percentage-based arrangements for space and imaging equipment. Percentage-based arrangements for billing and collections should be permitted.

Percentage-based arrangements for space and imaging equipment leases are prone to abuse and should be eliminated. Lease arrangements featuring flat-rate payments which are not tied to volume are less susceptible to abuse. However, RBMA recommends that percentage based fee arrangements continue to be allowed for billing and collection services even if it causes some variability in physician compensation. Percentage based fee arrangements are the most common method of compensation for billing and collections services, and provide appropriate incentives for quality and accuracy. We believe that percentage based fees for billing and collections services should be set at fair market value.

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Services Furnished "Under Arrangements" (Page 38186)

RBMA agrees with CMS' proposal to change the definition of "entity" in 411.351 to include not only the entity that submits claims to Medicare for DHS but also any person or entity that "performs" the DHS.

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Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions (Page 38190)

RBMA opposes the proposed denial of payment for an x-ray ordered by a non-treating physician for chiropractic patients.

RBMA believes that if chiropractic patients are referred to radiologists for imaging studies, then Medicare should pay for these imaging studies as they would for any other referred patient.

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TRHCA-Section 101(b): PQRI

General Comment

RBMA suggests that CMS expand the PQRI stakeholders to include hospitals and health information system (including radiology information system) vendors.

A physician's decision to participate in PQRI is somewhat dependent on the access to and ease of retrieving the required information. For hospital-based physicians to participate in PQRI, the hospital needs to be made aware of the information that is required and ensure that it is captured and communicated to the physician. Otherwise, potentially interested physicians will elect not to contribute to the program. Similarly, health information vendors can play an important role in easing the access and transmission of PQRI required information. PQRI information that is collected and stored electronically can be accessed and reported more easily than that in paper form. Many radiologists have elected to not participate in PQRI in 2007 because of their inability to retrieve or the difficulty of retrieving the required data. For example, the requirement in Measure 10 to report whether the patient had an imaging study within 24 hours of arrival to the hospital is difficult to obtain absent the cooperation of the hospital and of the vendors of hospital information systems.

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TRHCA-Section 101(d): PAQI

RBMA favors funding of the Physician Quality Reporting Initiative (PQRI) through the introduction of new money and not through the 2008 Medicare fee schedule update or by redistributing existing monies within the fee schedule.

RBMA commends the agency for policies that promote and/or incentivize the provision of quality health care. Many radiology practices are participating in the Physician Quality Reporting Initiative (PQRI). However, we believe that many more practices would enroll in PQRI if the bonus payments were sizeable enough to entice providers and to compensate them for the additional expenses incurred by participation. If additional funding is not available for PQRI bonus payments, we recommend that the PAQI fund be used to mitigate the cut in the 2008 conversion factor.

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RVU Impacts

Combined Impacts (Page 38214)

RBMA opposes the estimated 9.9 percent reduction planned for the 2008 Medicare fee schedule conversion factor.

Medicare payments comprise a significant portion (approximately 30 to 40 percent) of a typical radiology practice's revenue. Moreover, many radiology contracts with private payors are tied to Medicare's rates. Lastly, Congress through the Deficit Reduction Act (DRA) of 2005 enacted Medicare payment cuts targeting imaging and radiology. Therefore, mounting cuts in Medicare payments are beginning to have serious ramifications for radiology practices, forcing practices to make difficult choices which potentially impact patient care. For example, in a recent RBMA survey of its members, over 60 percent of the respondents planned to forgo imaging technology upgrades and reduce staff in response to the DRA. Additional Medicare payment reductions, like those proposed for 2008, would accelerate this process, forcing practices to consider even more drastic measures such as restricting office hours and eliminating non-viable modalities. This could have a significant impact on Medicare patients' access to quality diagnostic imaging facilities.

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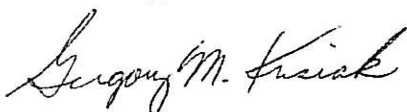
The RBMA appreciates the opportunity to comment on CMS' proposed rule for the 2008 Medicare physician fee schedule. If questions arise or additional information is needed, please feel free to contact RBMA's Executive Director, Michael R. Mabry at 703.621.3363 or mike.mabry@rbma.org.

Sincerely,



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