RBMA™
Building the Business of Radiology

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August 23, 2010

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1503-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8013

Dear Dr. Berwick:

Subject: Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2011: Proposed Rule

The Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the proposed rule for the 2011 Medicare physician fee schedule as published in the July 13, 2010 *Federal Register*.

Founded in 1968, the RBMA represents over 2,300 radiology practice managers and other radiology business professionals. In the aggregate, RBMA's influence 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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Comments on Specific Issues in the Proposed Rule

Practice Expense Relative Value Units (PE RVUs) (Federal Register page 40046)

RBMA remains concerned over the expense per hour figures for radiology used in CMS' practice expense methodology. We recommend that CMS re-open the Physician Practice Information Survey (PPIS) for additional radiology respondents.

RBMA continues to have concerns over the use of PPIS information for radiology in CMS' practice expense methodology. Radiology's PPIS information suffers from several shortcomings: (1) low number of respondents, (2) failure to distinguish between hospital-based and office-based radiologists, and (3) unexplainable difference between the expense per hour from the American College of Radiology's (ACR) Supplemental Survey and PPIS.

RBMA recognizes the importance of accurate practice expense information in CMS' practice expense methodology. To that end, we recommend CMS re-open the PPIS so that radiology and other medical specialties may contribute more robust practice expense data.

Proposed CY 2011 Expansion of the Imaging Technical Component MPPR Policy to Additional Combinations of Imaging Services (Federal Register page 40073)

RBMA recommends strongly against CMS' proposed expansion of the Multiple Procedure Payment Reduction (MPPR) to non-contiguous body areas and across the affected modalities (CT, CTA, MRI, MRA, and ultrasound).

CMS' proposed expansion of the MPPR in the rule (1) across all three modalities (CT, MRI, and ultrasound) and (2) to non-contiguous body sites goes far beyond both the statute and the Agency's 2005 final rule. Section 3135(b)(D) of the Patient Protection and Affordable Care Act (Public Law 111-148) directs the Secretary to "increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) [emphasis added] from 25 percent to 50 percent." The 2005 rule states (page 70261), "[w]e proposed applying the reduction only to procedures involving contiguous body areas within a family of codes, not across families [emphasis added], and to those multiple procedures that were provided in one session."

RBMA recognizes some economies of scale in the technical component of same modality studies of contiguous body areas during the same session. For example, certain activities such as greeting the patient/escorting the patient, providing education, obtaining consent, prepping the patient including setting-up an IV, and room clean-up are not repeated for the subsequent procedure. Please note that these "savings" are relatively minor in the aggregate and do not justify a 50 percent discount.

Non-contiguous studies nearly always involve patient repositioning, the application/removal of coils in the case of MRI and lead shields in the case of CT, different transducers in the case of ultrasound, use of contrast, changes to the imaging protocol, gantry orientation, etc. Thus, the economies referenced above are not present for non-contiguous studies involving the same modality.

We very strongly recommend against applying this policy to instances where multiple different modalities are employed (e.g., ultrasound and CT). Aside from greeting the patient, there are very few economies of scale with different modalities as each study is essentially a standalone procedure (new personnel involved, new set-up, new patient positioning, additional full exam time, and clean-up). Patients also need to move or be transported from one modality to another because the equipment is in different rooms on the same floor or on different floors. The realities of providing these services are simply at odds with the stated or implied rationale underlying the proposed MPPR expansion.

CMS cites as part of its rationale the 50 percent discount for multiple surgical procedures. RBMA disagrees. The surgical discount is intended to adjust for the duplication in physician work and practice expenses from pre-service office visits, pre-operative preparation, post-operative hospital care, and post-operative office visits. There is no comparable duplication in physician work or practice expense for imaging services, thus it would be incongruent to justify the MPPR on the basis of the multiple surgical discount policy.

RBMA also strongly recommends against a multiple procedure discounting scheme that targets the professional component (PC). In the rule, CMS states (on page 40074), "[w]e will continue to review other possible expansions of the MPPR policy to the TC and/or PC of imaging procedures or other diagnostic tests for the future". Radiologic studies result in a specific number of images to be interpreted by the physician. The number of images depends on the body site examined, the patient's clinical question, protocols, etc. Therefore, when multiple anatomic sites are studied, the number of images to be interpreted is cumulative as is the required physician work.

Improvements to the Physician Quality Reporting System (Federal Register page 40113)

RBMA recommends that the denominator in the Physician Quality Reporting Initiative (PQRI) bonus eligibility for radiology be based on CPT/ICD-9 combinations only for the specific line item in which the CPT/ICD-9 combination is present.

CMS attempted to facilitate physician participation in PQRI and increase the opportunity for bonus payments by counting combinations of CPT/ICD-9 codes across any date of service. However, this change has had the opposite effect on radiology providers because radiologists treat patients with multiple dates of service and for multiple reasons. For example, a CPT code reported today could be linked to an ICD-9 code from a previous date of service. As a result, specific CPT/ICD-9 pairings that would count towards bonus payments are instead decoupled leading to the PQRI denominator being overly inflated.

Modification of Equipment Utilization Factor for Advanced Imaging Services (Federal Register page 40120)

RBMA recommends that CMS based its utilization rate on actual data rather than on assumptions.

In the proposed rule, CMS plans to implement Section 1107 of the Health Care and Education Reconciliation Act of 2010 which calls upon the Secretary to use a 75 percent assumption in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment under the final rule published on November 25, 2009 effective January 1, 2011. Imaging procedures (namely CT and MRI) performed on diagnostic equipment costing $1 million or more will be affected by this change.

In 2009, RBMA was critical of CMS' 90 percent utilization rate proposal due to the insufficient evidence on which it was based. RBMA presented its survey findings of actual imaging centers to CMS at a meeting in Baltimore showing:

- Utilization rates for imaging modalities overall are consistent with Medicare's current 50 percent usage rate
- Utilization rates for "advanced imaging" (CT, MRI, Nuclear Medicine) are closer to Medicare's current rate than the 90 percent utilization "normative standard" recommended by MedPAC
- Rural imaging centers have lower utilization rates than non-rural centers, making them more financially vulnerable to excessive increases in the utilization rate

RBMA's survey did have the limitation of a relatively few respondents; however, the final results were based on nearly 300 equipment observations. RBMA's survey had more data points than the PPIS which CMS uses as its rationale for other proposed rule changes as noted previously.

We strongly recommend that CMS base its equipment utilization rate on actual data rather than on assumptions. RBMA recommends that CMS be open to revisiting this issue if presented with more robust data.

Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services (Federal Register page 40140)

RBMA recommends that hospitals be included in the "List of Alternate Suppliers" pursuant to disclosure requirements for the in-office ancillary services exception.

Section 6003 of the Patient Protection and Affordable Care Act of 2010 creates a new disclosure requirement for the in-office ancillary services exception to the prohibition on physician self-referral. For MRI, CT, and PET (along with other services the Secretary determines appropriate), the referring physician must inform a patient in writing at the time of the referral that the patient may obtain the service from someone/somebody else and be furnished with a list of alternative suppliers [emphasis added] in the geographic area where the patient resides.

RBMA believes that CMS is taking an overly literal interpretation of "suppliers" and, as a result, has incorrectly excluded hospitals from the list of alternative sites. We recognize CMS' logic in pointing out in the rule that Section 1861(d) of the Act defines supplier as "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title." Hospitals, on the other hand, are "facilities" and fall under the definition of "providers" per section 1861(u) of the Act. We cannot help but conclude that the "spirit" or a more lay interpretation of Section 6003 was for the self-referring physician to present to his/her patients a full accounting of alternative imaging facilities. In many areas, the community hospital is the largest provider of imaging services. Thus, the omission of hospitals from the alternative list is inconsistent and a potential source of confusion for Medicare beneficiaries.

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The RBMA appreciates the opportunity to comment on CMS' proposed Payment Policies under the Physician Fee Schedule for Calendar Year 2011. We stand ready, as always, to assist CMS with data and other information regarding the practical aspects of the business of radiology. 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,

Alicia Vasquez

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