RBMA™
Building the Business of Radiology

RADIOLOGY BUSINESS MANAGEMENT ASSOCIATION

10300 Eaton Place
Suite 460
Fairfax, VA 22030

703-621-3355 Direct
888-224-7262 Toll Free
703-621-3356 Fax

www.rbma.org

September 5, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1600-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8013

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

The Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Notice of Proposed Rule Making (NPRM) on the revisions to payment policies under the Medicare Physician Fee Schedule (MPFS) for CY 2014 as published in the July 19, 2013, *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.

****

General Comments

Since 2006, Medicare's payments to imaging have been cut 12 times, nine of which have directly targeted the technical component. Total cuts to computed tomography's (CT) technical component (TC) alone are in the range of 40 to 55 percent.[1] Yet, payment cuts to imaging are proposed yet again in 2014. First, more TC payment cuts are in store for CT and magnetic resonance imaging (MRI) with Medicare's 90 percent equipment usage rate. Second, because of: (1) a proposed change to CMS' Hospital Outpatient Prospective Payment System's (HOPPS) methodology for calculating Ambulatory Payment Classification (APC) weights using new cost-to-charge ratios for CT and MRI and (2) TC caps based on HOPPS rates imposed by the Deficit Reduction Act of 2005, the TC for CTs and MRIs could be facing cuts ranging from 12 to 35 percent. Third, if implemented, the proposal to use HOPPS and/or ASC rates to cap the non-facility practice expense relative values (NFPERVUs) will cause estimated payment reductions of 4 percent for radiation oncology, and 2 percent

[1] Neiman Report, Brief 01, October 20, 2012, "Medical Imaging: Is the Growth Boom Over?", page 2, Harvey L. Neiman Health Policy Institute, American College of Radiology

for interventional radiology.[2] Finally, ultrasound services will be subjected to cuts from policies contained in the CY 2014 MPFS proposed rule.

Comments on Specific Issues in the Proposed Rule

CY 2014 CPT Codes Subject to 90 Percent Usage Rate (*Federal Register,* page 43290)

RBMA reiterates its previous opposition to the 90 percent utilization rate assumption for imaging equipment costing $1 million or more. We would also oppose the expansion of this assumption to other imaging modalities.

As a result of the American Taxpayer Relief Act of 2012 (ATRA), CMS is compelled to apply the 90 percent usage rate assumption to services (MRI and CT) in CY 2014 and subsequent years for which the 75 percent assumption applied in CY 2013. RBMA continues to maintain that a 90 percent equipment usage assumption for CT, MRI, or any other imaging modality for that matter is arbitrary and inconsistent with standard practice in freestanding (non-hospital) imaging centers. In previous comment letters and face-to-face meetings, RBMA has argued that:

1. MedPAC's 90 percent equipment rate assumption represents a normative standard that is unrealistic and based on flawed information.
2. CMS' previous efforts to implement a 90 percent usage rate assumption were based on insufficient evidence and failed to meet the requirement of the Balanced Budget Act of 1997 (BBA) that resource-based relative values reflect actual and complete cost data.
3. Our own research found that:
    - Utilization rates for imaging modalities overall were consistent with Medicare's 50 percent usage rate
    - Utilization rates for "advanced imaging" (CT, MRI, Nuclear Medicine) are closer to a 50 percent rate than the 90 percent utilization normative standard recommended by MedPAC
    - Rural imaging centers had lower utilization rates than non-rural centers, making them more financially vulnerable to an excessive increase in the utilization rate
4. "Real world" scheduling demands (e.g., lunch and other breaks, irregular exams, emergency exams, maintenance, weather, breakdowns, and "no shows") make achieving a 90 percent utilization rate nearly impossible, even in the busiest centers, and not representative of the norm.

Using HOPPS and ASC Rates in Developing Practice Expense (PE) Relative Value Units (RVUs) (*Federal Register,* page 43296)

RBMA opposes CMS' proposed use of HOPPS and ASC rates to cap practice expense relative value units in the non-facility setting.

In its rule, CMS proposes to begin capping payments for services performed in the non-facility setting when those payments are greater than what is paid when the same service is performed in the hospital outpatient department (HOPD) or ambulatory surgical center (ASC) setting. CMS offers the following two arguments in support of this proposal: (1) there are greater resource costs when a service is performed in a facility (e.g., HOPD, ASC) compared to a non-facility setting and (2) the HOPPS and ASC cost data are more reliable than cost data collected for the resource-based relative value scale (RBRVS). As a result, the agency concludes:

---

[2] Table 72, July 19, 2013 *Federal Register,* page 43514

> We believe that this proposal provides a reliable means for Medicare to set upper payment limits for office-based procedures based on relatively more reliable cost information available for the same procedures when furnished in a facility setting where the cost structure would be expected to be somewhat, if not significantly, higher than the office setting.[3]

Greater Resource Costs Facility vs. Non-Facility

Facilities, particularly hospitals, do enjoy some cost advantages relative to non-facilities such as physician offices, freestanding imaging centers, and independent diagnostic testing facilities (IDTFs). For example, hospitals are able to command greater discounts from suppliers due to their size and volume of services. Hospitals that are part of health systems or members of group purchasing organizations (GPOs) enjoy even more pricing leverage with suppliers. This scale of purchasing power is elusive for most physician offices and independent imaging centers. Moreover, the vendors in question are those in medical equipment, implantable devices, and medical supplies which have the greatest impact on direct costs per procedure in the MPFS.

HOPPS/ASC vs. MPFS Data

CMS claims that the HOPPS payment rates are more reliable because they are based on auditable data that is updated on an annual basis. Hospital cost reports have been viewed as inaccurate partly because most hospitals have a history of inaccurately calculating direct costs by modality. The breakout of capital intensive modalities such as CT and MRI results in inaccurate costing if hospitals continue to assign CT and MRI costs using the less accurate square footage methodology. This issue results in continued inaccuracy when attempting to calculate the direct costs per procedure. CMS' HOPPS methodology has to estimate costs based on cost-to-charge ratios (CCRs), which are derived from hospital cost reports, and hospital charges, which are based on hospital charge masters that are often out-of-date. These costs are then compressed by estimating the geographic mean to calculate the APC weights. In contrast, the resource costs in the MPFS are developed using a "bottom-up" PE methodology consisting of assignable direct costs (e.g., supplies, equipment, and clinical labor) to procedures. These estimates of direct costs are viewed and vetted rigorously by the American Medical Association's (AMA) RVS Update Committee (RUC). Historically, CMS has accepted the majority of the RUC's recommendations. While neither the HOPPS nor RBRVS approaches are without their shortcomings, RBMA does not see how CMS can conclude that HOPPS/ASC cost data are better than those utilized under MPFS.

Additional areas of concern related to this proposal include:

- Services with high cost supplies/equipment – An analysis conducted by the AMA's RUC shows that of the 211 codes affected by this policy, services with high direct practice costs are disadvantaged. For example, 82 percent of the affected codes have direct practice expenses that exceed the proposed payment rate cap. This means that for the majority of the impacted codes, CMS will not consider the total clinical labor, supplies, and equipment, much less the indirect costs that are key components of the codes' PERVUs.

---

[3] July 19, 2013 *Federal Register,* page 43298

- Beneficiary cost and access issues – Since many of the affected procedures are low volume, it is likely that hospitals could absorb lower payment for these services. However, this is likely not the case for physician offices which may have to stop offering an affected service in the office setting. As a result, costs to both beneficiaries and Medicare will increase. Forcing these services into the hospital setting will impact patients in rural as well as low income areas.

- Use of disparate years to determine payment rates – CMS proposes to compare the 2014 non-facility PERVU to the 2013 HOPPS/ASC payments. This means the comparison will ignore the proposed conversion factor updates of 1.8 percent to HOPPS and 0.9 percent to ASC payment rates respectively. If CMS implements this proposal, RBMA recommends the agency use the most current 2014 HOPPS/ASC payment rates in its analysis.

The Multiple Procedure Payment Reduction (MPPR) Policy (*Federal Register,* page 43308)

RBMA welcomes CMS' decision not to expand the MPPR for CY 2014. We continue to disagree, however, with the MPPR's scope and amount of reductions and oppose any further expansion of the MPPR.

While we appreciate CMS has proposed not to expand the MPPR for CY 2014, RBMA continues to maintain the current policy is excessive with respect to:

1. *Professional Component (MPPR-PC)*

   RBMA continues to strongly oppose a multiple procedure discounting scheme that targets the professional component (PC). Radiologic studies result in a specific number of images to be interpreted by a radiologist. The number of images depends on the body site examined, the patient's clinical question(s), medical protocols, etc. Therefore, when multiple anatomic sites are studied, the number of images to be interpreted is cumulative as is the required physician work.

   RBMA would like to emphasize the cognitive nature of a radiologist's interpretation and point out there are few efficiencies to be gained similar to those found in the technical component (e.g., supplies, equipment). If two procedures are performed, two procedures must be fully interpreted and the fact that one patient had the two studies has no bearing on the end work product.

   Any economies of scale in interpreting multiple imaging services are relatively minor and do not justify the imposed 25 percent discount. In a 2011 article published in the *Journal of the American College of Radiology* (JACR),[4] the authors, many of whom have a thorough understanding of the RUC process, looked for areas of physician work duplication when two or more procedures are interpreted by the same physician during the same session. They estimated the amount of physician work savings related to the professional component ranged from 2.96 to 5.45 percent, depending on modality.

[4] Journal of the American College of Radiology Vol. 8, Issue 9, Pages 610-616

RBMA also questions the application of MPPR to the entire professional component. The professional component is comprised of physician work, practice expense, and malpractice relative values. A radiologist's malpractice liability correlates with the type of studies interpreted/performed and does not decrease if studies are interpreted in the same session. The radiologist's practice expenses are unchanged if multiple studies are performed together. Hospital-based radiologists, who are compensated through professional component payments, must still incur costs associated with billing and collections, practice management/administration, benefits, maintenance of credentials, etc. RBMA has commented previously to CMS that the MPPR disadvantages tertiary care centers in particular since a significant number of procedures performed together are done so in the emergency room setting, i.e., with beneficiaries who are typically the most ill and who demand the most immediate attention.

2. *Same vs. Different Physicians Within the Same Practice*

There are no shared efficiencies when imaging studies for the same patient are interpreted by different radiologists in the same group practice. This finding was documented in a 2013 study published in the *Journal of the American College of Radiology* (JACR),[5] which found the maximum potential for duplication of physician work in the professional component amounted to less than 2 percent. This outcome makes sense in that, even though the patient is the same, the radiologists still must expend the same amount of energy and cognitive intellect reviewing the patient's clinical information, historical data, etc. because there may be separate complaints involved for different studies or additional relevant history on one of the studies. This is true whether the procedure is interpreted by the same or different radiologists. Multiple studies are sometimes segregated in the Picture Archiving and Communication System (PACS) with corresponding patient histories to facilitate subspecialized interpretations. Other times, one study will be read while another is delayed to accommodate the comparison of relevant prior studies resulting in readings at separate times by separate radiologists. Patient preparation delays can cause studies to be presented for interpretation at different times, again resulting in separate readings. Finally, operationalizing the MPPR-PC at the group practice level presents a significant burden on radiology practices in terms of time, effort, and cost. The policy's inherent ambiguities present unwarranted compliance risks for radiologists and their practices.

Future Expansion of the MPPR

In past MPFS rulemaking, CMS has signaled that the agency will continue to aggressively look for efficiencies in other sets of codes. Possible proposed areas of MPPR expansion have included:

- Apply the MPPR to the TC of All Imaging Services
- Apply the MPPR to the PC of All Imaging Services
- Apply the MPPR to the TC of All Diagnostic Tests

RBMA opposes further expansion of the MPPR. When it comes to imaging across modalities, there are very few economies of scale, aside from greeting the patient, as each study is essentially a standalone procedure (new personnel involved, new set-up, new patient positioning, additional full exam time, and clean-up). We believe the same would hold true between imaging and non-imaging diagnostic tests. Additionally, there may be a failure to capture all expenses. The PERVU methodology assumes the patient enters the imaging

[5] Journal of the American College of Radiology, Vol. 10, Issue 4, April 2013

room, has the procedure, and then leaves. However, with multiple imaging services, there is the additional clinical staff time of transporting the patient between rooms and/or floors as well as additional time for the patient to prepare for different types of studies (e.g., filling/emptying one's bladder, administering barium).

RBMA vehemently opposes the MPPR being applied to the professional component of imaging services because: (1) multiple studies result in additional images for interpretation, (2) there is evidence that the duplication of physician work is small, and (3) the professional component is comprised of practice expense and malpractice relative values that should not be affected.

Collecting Data on Services Furnished in Off-Campus Provider-Based Departments *(Federal Register,* page 43626*)*

RBMA recommends CMS issue better guidance on the definition of "off-campus provider-based" prior to any effort to collect information regarding those entities such as the services they provide or the payments they receive.

In the proposed rule, CMS expresses interest in collecting information about off-campus provider-based outpatient departments to better understand hospitals' acquisition of physician offices and its impact on the Medicare program.

It is RBMA's understanding there is variability currently in how the Medicare Administrative Contractors (MACs) treat off-campus provider-based facilities. CMS' data collection efforts may result in confusing and misleading data without better and/or more consistent definitions or guidance.

****

The RBMA appreciates the opportunity to comment on CMS' CY 2014 Medicare Physician Fee Schedule proposed rule. 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,

Wendy Lomers

Wendy Lomers, MBA, CPA
President, RBMA Board of Directors

cc: Marc Hartstein, CMS
Christina Ritter, PhD, CMS
Ken Marsalek, CMS
Ryan Howe, CMS