RBMA™
Building the Business of Radiology

RADIOLOGY BUSINESS MANAGEMENT ASSOCIATION

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August 31, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1590-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8013

Subject: Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2013: Proposed Rule

Dear Ms. Tavenner:

The Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the proposed rule for the 2013 Medicare Physician Fee Schedule (MPFS) as published in the July 30, 2012 *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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General Comments

The downward trend in Medicare payments for imaging continues unabated and the blanket proposals found in this proposed rule once again adversely affect providers of diagnostic imaging services. More importantly, there is scant evidence or data provided to support the proposed changes. Previous policies have impacted primarily imaging centers through reductions in Medicare's technical component payments. Negative payment policies in this proposed rule will significantly impact not only imaging centers but also radiologists who practice in hospital settings. RBMA believes the continued erosion of Medicare payments for imaging will eventually drive out of business radiologists who are providing high-quality and appropriate imaging services to Medicare beneficiaries. The unintended consequences may well be a material and adverse ripple effect on the health and economies of the communities they serve. The financial impact of these payment cuts extends far beyond Medicare since a large percentage of commercial carriers base their payments on the Medicare fee schedule or its relative values. History also shows that commercial payers have rapidly adopted Medicare's payment policies, further compounding the impact of these policies.

Comments on Specific Issues in the Proposed Rule

Equipment Cost Per Minute: "Sliding Scale" Approach to Interest Rate Assumption (*Federal Register* page 44731)

CMS' proposed three levels of "sliding" interest rates from the Small Business Administration are overly complicated and do not reflect the cost of capital set forth in the 1997 practice expense methodology. Instead, RBMA recommends a single rate based on published weighted average cost of capital (WACC) figures updated at least every three years. Furthermore, we recommend a multi-year transition from the current interest rate assumption to the new rate.

RBMA acknowledges that interest rates are at an all-time (arguably artificial) low as a result of various macroeconomic issues and that the current 11 percent interest rate assumption used now by CMS in estimating equipment expenses has been in place since 1998.

In the rule, CMS proposes to replace the current 11 percent interest rate assumption used in estimating equipment costs with a "sliding scale" approach based on the current Small Business Administration (SBA) maximum interest rates for different categories of loan size (price of the equipment) and maturity (useful life of the equipment). The maximum interest rates for SBA loans are as follows:

- Fixed rate loans of $50,000 or more must not exceed Prime plus 2.25 percent if the maturity is less than seven years, and Prime plus 2.75 percent if the maturity is seven years or more.
- For loans between $25,000 and $50,000, maximum rates must not exceed Prime plus 3.25 percent if the maturity is less than seven years, and Prime plus 3.75 percent if the maturity is seven years or more.
- For loans of $25,000 or less, the maximum interest rate must not exceed Prime plus 4.25 percent if the maturity is less than seven years, and Prime plus 4.75 percent if the maturity is seven years or more.

Unnecessarily Complicated

RBMA views the proposed three sliding interest rates to be overly complicated for CMS to administer. The proposal would create six interest rates depending on: (1) the useful life and (2) price of the equipment. These six interest rates would then be subject to changes in the Prime rate which frequently occur annually and often multiple times within the same year. Such changes in the prime rate will cause fluctuations in Medicare's PERVUs and increases in the administrative costs to CMS and providers.

Small Business Administration's Maximum Interest Rates

Second, the SBA's interest rates may not be appropriate for the purpose of PERVU setting. The SBA's maximum interest rates and loan amounts are determined by Congress (13CFR120) and are intended to provide an incentive to lend rather than reflect the actual cost of borrowing. Specifically, the higher maximum interest rate for small loans ($25,000 or less) is to encourage lenders to make smaller commercial loans as many lenders do not make commercial loans for less than a certain dollar threshold. The loan amounts are arbitrary and unrelated to equipment costs for medical practices.

The interest rates that a provider can obtain are a function of individual credit, the size of the loan, and the assets of the practice. It is not reasonable to use SBA loan maximum interest guidelines as a benchmark since these loans have lower interest rates and there is no evidence that the SBA's interest rates correlate with those offered by commercial banks and other private lending institutions. We believe that it is more likely that physicians are obtaining loans from private institutions to finance equipment purchases. In other areas of the fee schedule that require data (malpractice RVUs, etc.), CMS collects information directly from physicians or from relevant data sources. By not using this methodology, CMS runs the risk of basing their assumptions on inaccurate information.

Inconsistent with Statute and PERVU Methodology

RBMA questions whether CMS' proposed sliding scale methodology is consistent with section 1848 (Payment for Physicians' Services) of the Social Security Act which requires that CMS make payments under the MPFS using national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. In general, interest rates correlate with maturity and amount financed (i.e., the longer the loan and greater the amount, the higher the interest rate). Capital intensive specialties like radiology, radiation oncology, and nuclear medicine invest in expensive technology and, thus incur higher interest expenses than the rest of medicine in general. Yet, CMS' proposal would assign these capital intensive specialties the lowest interest-related costs. Additionally, start-up or smaller ventures, which would encompass many medical practices particularly those in rural or developing markets, usually have higher financing costs than larger, institutional borrowers. This is because they often come without equity guarantees which are a hidden, but very real cost, that needs to be considered.

CMS issued a proposed rule on June 18, 1997 (*Federal Register*, volume 62, number 117) which contained the agency's methodology for calculating resource-based practice expense relative values in accordance with Section 121 of the Social Security Act (Public Law 103–432), enacted on October 31, 1994. CMS' equipment pricing model was to use as one of its variables "cost of capital." Unable to find loan data from physician practices, CMS' consultant (Abt Associates) developed a proxy based on prevailing loan rates for small businesses. RBMA believes that the rate used in the equipment calculation should reflect the underlying financing cost of providers rather than a "point-in-time" estimate. That is, the rate used in the calculation should represent the average rates in effect at the time the equipment was purchased. For example, CMS' methodology should take into account the cost of capital derived when financing a piece of equipment in 2007 when the Prime rate was in the 7 to 8 percent range as well as that cost when the same equipment is financed today.

Weighted Average Cost of Capital

The weighted average cost of capital (WACC) is the rate of return that capital could be expected to earn in an alternative investment of equivalent risk (i.e., the opportunity cost of using the funds to buy equipment versus using those same funds elsewhere). WACC is a truer measure of the cost of buying equipment because it takes into account equipment financing and equity financing (i.e., funded through on-hand cash). Expressed as a percentage like an interest rate, WACC should work within CMS' existing equipment formula. In addition, annual WACC estimates are available readily through sources such as Ibbotson (Morningstar). For these reasons, RBMA recommends that CMS incorporate WACC into its PERVU methodology.

Regular Updates

RBMA recommends that the WACC estimate used in CMS' PERVU methodology be updated at least every three years to: (1) keep abreast of changes in cost of capital and (2) minimize fluctuations in PERVUs caused by annual updates.

Transition

The switch from the current interest rate assumption will be hardest felt by capital-intensive specialties like radiology, radiation oncology, cardiology and non-facility providers (e.g., independent diagnostic testing facilities, imaging centers, radiation therapy). RBMA, therefore, recommends that the change from the current interest rate assumption be phased-in over a period of three or four years.

Potentially Misvalued Codes Under the Physician Fee Schedule *(Federal Register* page 44735)

RBMA is concerned about the proposed payment cuts to radiation oncology services and the impact these cuts could have on technological advancements and patient care.

RBMA is extremely concerned about the proposed payment cuts to radiation oncology services. A vast majority of cancer patients receive radiation as part of their treatment and these cuts, if implemented, will have a significant impact not only on providers, but on patients as well. The development of new technology and techniques, which has led to improved outcomes, also will be negatively impacted by these payment reductions. RBMA also questions the appropriateness of basing a review of Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Body Radiation Therapy (SBRT) on patient marketing materials that do not fully account for all of the time involved in providing these complex and lifesaving medical procedures.

MPPR Policy Clarifications: Apply the MPPR to the PC and TC of Advanced Imaging Procedures to Physicians in the Same Group Practice (*Federal Register* page 44748)

RBMA adamantly opposes CMS' proposed application of the Multiple Procedure Payment Reduction (MPPR) policy to the professional component to physicians in the same group practice. Moreover, RBMA is unconvinced that the significant operational limitations that exist with respect to implementing the MPPR within group practices have been addressed.

Professional Component "Savings"

RBMA continues to oppose a multiple procedure discounting scheme that targets the professional component (PC). Radiologic studies frequently result in a specific number of images that are to be interpreted by the radiologist. The number of images is contingent upon 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 a facility setting (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 on the same day in the same session has no bearing on the end work product.

In an article in the *Journal of the American College of Radiology* (JACR), 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 that the amount of physician work savings ranged from 2.96 to 5.45 percent, depending on modality, when based on the professional component.

CMS cites the discount for multiple surgical procedures as part of its rationale. 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 to the professional component based on the multiple surgical discount policy.

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 the exams are performed together. The radiologist's practice expenses are also unchanged if multiple studies are performed together. In the imaging center environment, the technical component rates have repeatedly been the target of payment policy reductions. 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.

A preliminary analysis of over two dozen radiology practices shows an average reduction in Medicare payments from the MPPR-PC of approximately 5 percent. Perhaps more significantly, practices that serve trauma and cancer centers are hardest hit by the MPPR-PC with estimated Medicare payment reductions in the 7 to 8 percent range. Given the severity of their disease or injury, such patients are more complex to diagnose and are more apt to require multiple imaging studies during their sessions of care.

Same vs. Different Physicians

There are no shared efficiencies when imaging studies are interpreted by different physicians in the same practice. Even though the patient is the same, the radiologists still must expend the same amount of energy 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 one 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 waiting on relevant priors resulting in readings at separate times by separate radiologists. Patient preparation delays can cause studies to appear for interpretation at different times, again resulting in separate readings.

Significant Operational Limitations Unresolved

The MPPR-PC will place significant administrative burdens on radiology practices. This is because the radiology systems in place today are not designed to distinguish between imaging procedures performed during the "same" or "different" sessions with any degree of

reliability. If the MPPR-PC is implemented, the challenge to back-office operations will be to determine when studies have been performed in separate sessions in order to add the -59 modifier. The RBMA has spent considerable time speaking to, and working with, its members on this issue and has concluded that today's systems offer no practical method to reliably and efficiently make this distinction. The time of the provision of the technical exam and subsequent interpretation is, by and large, not currently provided to radiologists by their hospitals/facilities, nor are billing systems currently equipped with the required fields to capture this information. This challenge is complicated further when the issue of same versus different interpreting physician(s) is taken into account.

In correspondence from December 2011 and in the CY 2013 MPFS proposed rule, CMS cites "operational limitations" for not implementing the MPPR-PC within group practices in CY 2012. In the proposed rule, CMS goes on to say that the operational problems have been resolved. Yet, the agency fails to disclose how the operational problems have been resolved and thus provides no guidance to physician practices and it's Medicare Administrative Contractors (MACs) on how to proceed.

We see the following operational problems associated with applying the MPPR-PC to any physician within the same group practice:

1. "Separate Sessions"

   In the CY 2012 MPFS final rule, CMS states that, "[f]or purposes of the MPPR on the PC, scans interpreted at widely different times (such as in the emergency situation noted) would constitute separate sessions..." CMS does not offer guidance on separate sessions other than providers should exercise judgment when using the -59 modifier.

2. Legacy Information Systems and Data-Feeds Not Ready

   Radiology practices will have difficulty tracking technical component provision and subsequent interpretation times for purposes of implementing the MPPR-PC, particularly hospital-based radiologists who rely on data feeds provided by their hospitals' multiple information systems. Regardless of whether a hospital-based radiologist does his/her billing in-house or outsources it to a third-party, reliance on the hospital for the data required for billing is common across both models. While this data-feed typically contains patient demographic, insurance coverage information, and dictated reports, times of the technical component provision and interpretation are not commonly included in the transcription. Consequently, it is nearly impossible for coders and billers to know on the back-end when the MPPR-PC applies and when it does not.

   Moreover, without a better understanding of CMS' expectations, the process of readying these systems cannot be started nor can estimating the associated costs of making these changes. This lack of clarity creates compliance concerns for both providers and billing companies.

3. -59 Modifier

   The CY 2012 MPFS final rule directs providers to use the -59 modifier to indicate interpretations for the same patient on the same day were performed during separate sessions, thus overriding the MPPR-PC. However, the -59 modifier is also used for the National Correct Coding Initiative (NCCI) edits and there are many imaging scenarios which put the MPPR and the coding edits at odds. This presents a quandary for both radiology practices and CMS' Medicare Administrative Contractors (MACs).

For example, when an MRA of the head and an MRI of the brain are performed on the same patient on the same day and are interpreted by the same physician during the same interpreting session, it is appropriate per CCI guidelines to report a -59 modifier to bypass the coding edit. However, a policy conflict arises because the MPPR crosses modalities and would apply to physicians in the same group practice thus making this example ineligible for the -59 modifier.

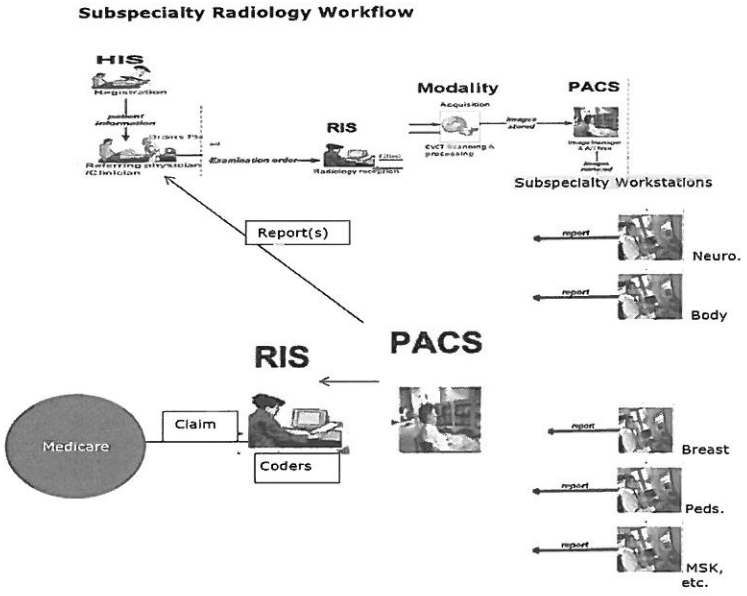
4. Definition of a Group Practice

   In the CY 2013 proposed rule, CMS defines a group practice by its National Provider Identification (NPI) number, "... we will apply the MPPR to both the PC and the TC of advanced imaging procedures to multiple physicians in the same group practice (same group NPI)."

   CMS' NPI-based definition of a group is problematic because many radiologists are enrolled in Medicare with entities other than their own group practice or a hospital/facility may have its imaging services provided by different groups each with its own NPI.

5. Workflow and Subspecialty Radiology

   Radiology workflow systems (as depicted in the illustration) triage studies to subspecialty radiologists who interpret the studies and generate reports. Billing systems submit separate claims per study. If two separate physicians read studies on the same patient, billers and billing systems will have difficulty attaching the -59 modifier appropriately.



Taken collectively, operationalizing the MPPR-PC at the group practice level presents a significant burden on radiology practices in terms of time, effort and cost. RBMA is concerned that the inherent ambiguity associated with: (1) distinguishing between same and different sessions and (2) same vs. different physicians present undeserved and unwarranted compliance risks for radiologists and their billing managers. For many

reasons, not the least being compliance reasons, same session exams are almost always dictated on separate reports, and this is particularly true of cross-modality studies. Exams, even same session exams, are frequently performed at widely separated intervals, sometimes hours apart (e.g., for exam prep and/or scheduling reasons or if a radiologist is waiting for prior studies for comparative purposes). This variability is present in report dictation times as well, making them unreliable for determining separate sessions for MPPR.

Proposed MPPR for the TC of Cardiovascular and Ophthalmology Services (*Federal Register* page 44748)

RBMA recommends strongly against CMS' proposed expansion of the Multiple Procedure Payment Reduction (MPPR) to certain cardiovascular and ophthalmology services.

In the rule, CMS proposes to apply a 25 percent multiple procedure payment reduction (MPPR) to select cardiovascular and ophthalmology procedures. Many of the procedures affected are performed commonly by radiologists, thus RBMA questions CMS' estimate of potential efficiencies from multiple services of up to 57 percent and 62 percent for cardiovascular and ophthalmology, respectively. Where efficiencies exist, they are usually confined to certain pre- and post-procedure services which, in the aggregate, do not justify the proposed 25 percent reduction.

Physician Compare Website (*Federal Register* page 44802)

RBMA urges CMS to continually update the Physician Compare website with current and accurate physician and physician practice information.

When launched in December, 2010, the Physician Compare website was designed to help patients find health professionals in their communities by including: (1) contact and address information for offices, (2) the professional's medical specialty, (3) where the professional completed his or her degree as well as residency or other clinical training, (4) whether the professional speaks a foreign language, and (5) the professional's gender.

Unfortunately, shortly after the launch, RBMA members reported several problems with the website:

1. Incorrect ZIP codes for physicians
2. Missing, incomplete, or outdated physician information (e.g., physicians no longer with the practice, physicians not in the practice, physicians missing from the practice)

While we believe CMS has taken steps to rectify these initial problems, the usefulness of the Physician Compare website will continue to depend on it having relevant, accurate and complete information. RBMA proposes that measures that are irrelevant to specific specialties be removed to improve the data. We also propose that a system be established to allow providers the ability to review and comment on their data prior to publishing on the Physician Compare Website to assist in providing more accurate data.

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The RBMA appreciates the opportunity to comment on CMS' proposed Payment Policies under the Physician Fee Schedule for Calendar Year 2013. 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,

Robert T. Still
President, RBMA Board of Directors

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