



September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma:

The American Society of Neuroradiology (ASNR) represents over 5,000 physicians specializing in the field of neuroradiology. As the preeminent society concerned with the diagnostic imaging and image-guided intervention of diseases of the brain, spine, and head and neck, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Proposed Rule.

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

- Proposed Valuation of Specific Codes:
CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492)
Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546)
Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549)

CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492)

The ASNR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.28 RVUs for CPT code 70490, 1.38 RVUs for CPT code 70491, and 1.62 RVUs for CPT code 70492.

We disagree with the potential crosswalk of CPT code 70490 to 72125 at 1.07 RVUs. While these codes have the same intra-service time, the clinical work is different, due to the patient

population and intensity of the services provided. CPT code 72125 is a CT of the cervical spine, which excludes many of the soft tissue structures in the neck to concentrate on the osseous structures in the cervical spine, usually in the setting of trauma. CPT code 70490 is a CT covering both the soft tissues in the neck and the cervical spine, which is more often performed in patients with malignancy or infection involving the complicated soft tissue planes in the neck that may also involve the bony spine. These differences in patient population and the anatomy included in the exam justify the higher work value for 70490 compared to 72125.

The ASNR also disagrees with the methodology proposed to use an incremental difference between the suggested crosswalk and target code as CMS proposed for 70490 to similarly decrease the values of contrast enhanced codes, 70491 and 70492. There is not a standardized difference in work between the without and with contrast codes because each exam is different depending upon the modality, clinical condition, typical patient, and body part being examined. The value of the RBRVS is its ability to capture these intensity differences and appropriately account for them in each clinical context.

Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546)

The ASNR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.20 RVUs for CPT code 70544, 1.20 RVUs for CPT code 70545, and 1.48 RVUs for CPT code 70546.

MRI and MR Angiography are complex imaging modalities and sometimes the physics is counterintuitive. The ASNR recognizes this as a potential source of confusion, and we appreciate the opportunity to discuss the clinical labor times related to acquiring MR angiography images. Please note that the RUC-submitted PE times are accurate, and the perceived discrepancy is because of the unique physics related to acquiring MR Angiography images as opposed to the typical MRI. During an MR Angiogram with contrast, images are acquired of a "blood pool of contrast" as opposed to enhancement of soft tissues or masses in a typical MRI with contrast. Blood pool imaging can be performed more quickly than the typical MRI evaluating for enhancement because of the higher signal to noise ratio of contrast within the blood vessels (i.e. high relaxivity) compared to contrast diffused throughout the soft tissues.

The parameters used to acquire the images are different, taking advantage of the chemical properties of gadolinium contrast when it is in high concentration (i.e. contained only within the blood vessels) versus low concentration (i.e. in the soft tissues). In the absence of intravenous gadolinium contrast, the acquisition of images takes a longer time to visualize the blood vessels because the signal received from the vessels is much lower compared to the adjacent soft tissues/structures. Once intravenous contrast is given, the scan time decreases because the contrast pools in the vessels, increasing their relative signal. As such, less time is required to acquire post contrast MRA images compared to the without contrast images because the signal from these vessels is much stronger than the adjacent soft tissues/structures.

Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549)

The ASNR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.20 RVUs for CPT code 70547, 1.50 RVUs for CPT code 70548, and 1.80 RVUs for CPT code 70549.

As previously noted, MRI and MR Angiography are complex imaging modalities and sometimes the physics is counterintuitive. The ASNR recognizes this as a potential source of confusion and appreciates the opportunity to discuss the clinical labor times related to acquiring MR angiography images. Please note that the RUC-submitted PE times are accurate, and the perceived discrepancy is because of the unique physics related to acquiring MR Angiography images as opposed to the typical MRI. During an MR Angiogram with contrast, images are acquired of a "blood pool of contrast" as opposed to enhancement of soft tissues or masses in a typical MRI with contrast. Blood pool imaging can be performed more quickly than the typical MRI evaluating for enhancement because of the higher signal to noise ratio of contrast within the blood vessels (i.e. high relaxivity) compared to contrast diffused throughout the soft tissues. The parameters used to acquire the images are different, taking advantage of the chemical properties of gadolinium when it is in high concentration (i.e. contained only within the blood vessels) versus low concentration (i.e. in the soft tissues). In the absence of intravenous gadolinium contrast, the acquisition of images takes more time to visualize the blood vessels because the signal received from the vessels is much lower compared to the adjacent soft tissues. Once intravenous contrast is given, the scan time decreases because the contrast pools in the vessels, increasing their relative signal. As such, less time is required to acquire post contrast MRA images compared to the without contrast images because the signal from these vessels is much stronger than the adjacent soft tissues/structures.

The ASNR appreciates the opportunity to provide comments on the CY 2018 MPFS proposed 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 ASNR looks forward to continued dialogues with CMS officials about these and other issues affecting neuroradiology. If you have any questions or comments on this letter, please contact Rahul Bhala at 630.574.0220 x 235 or via email at rbhala@asnr.org.

Respectfully Submitted,

A handwritten signature in cursive script, appearing to read 'Jacqueline Bello', with a stylized flourish at the end.

Jacqueline Bello, MD, FACR

Cc: Ryan Howe, CMS
Tamara Syrek Jensen, CMS
Joseph Hutter, MD, CMS
JoAnna Baldwin, CMS
Sara Fulton, CMS

Mary Beth Hepp, ASNR
Greg Nicola, MD, FACR. ASNR
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