



# ASNR

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December 28, 2011

Marilyn Tavenner  
CMS Acting Administrator  
Chief Operating Officer  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1524-FC  
Mail Stop 314G  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**Re: CMS-1524-FC; Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule; Signature on Requisition, and Other Revisions to Part B for CY 2012; Final Rule**

Dear Ms. Tavenner:

The American Society of Neuroradiology (ASNR) represents 4,800 physicians specializing in the field of neuroradiology. We are 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 comment on the Medicare Physician Fee Schedule Final Rule, published on November 28, 2011.

First, we will comment on the expansion of the Multiple Procedure Payment Reduction (MPPR) rule to the professional component of advanced diagnostic imaging. Next, we will discuss the physician work for CT spine codes (72125, 72128 and 72131). Finally, we will comment on the physician work for Kyphoplasty and Vertebroplasty codes (22520-22525).

### **Expansion of Multiple Procedure Payment Reduction (MPPR) Rule**

In the 2012 Final Rule, CMS stated that it would implement the expansion of the Multiple Procedure Payment Reduction (MPPR) which will impose a 25 percent reduction to the professional component of second and subsequent advanced diagnostic imaging services administered to the same patient, by the same physician, during the same session, on the same day. While the ASNR appreciates that CMS retreated from the original proposed reduction of 50 percent, we remain disappointed in the 25 percent reduction policy, which is not supported by peer-reviewed documented evidence of efficiency.

This policy is based on the assumed efficiencies in providing multiple XXX global services in the same session due to alleged duplication of physician work, primarily in the pre-service and post-service periods. We believe any small potential efficiencies have already been factored into

the valuation of these stand-alone codes at the RUC. The few examples of more significant efficiencies are being handled in thoroughness and great detail through the code-bundling process of the Relativity Assessment Workgroup. As stated in our proposed rule comment letter, the ASNR is concerned that the expansion of the MPPR rule indicates mistrust in the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process, and that the proposed MPPR expansion is a manifestation of CMS attempting to marginalize the functions of the AMA RUC.

The Department of Health and Human Services webpage on transparency states: “We believe that transparency and data sharing are of fundamental importance to our ability to achieve HHS’s strategic goals of advancing the health and well-being of the United States.”<sup>1</sup> The ASNR agrees that transparency and data sharing are crucial for advancing the quality of healthcare and payment policy, and encourages the application of this principle to the MPPR analysis performed for the Final Rule as well as future decision-making.

*The ASNR has several points that CMS should consider regarding the application of such an arbitrary and drastic payment reduction:*

- **Additional Analysis by CMS in Final Rule Incomplete, Not Transparent, and Flawed:** CMS published results from an analysis of 12 high volume code pairs where vignettes were available. The ASNR is concerned that this analysis was insufficient in scope for analyzing a policy which will have a substantial impact on both Medicare beneficiaries and also the field of Radiology.

Please publish this analysis in its entirety, instead of solely providing the results and a basic description of the process. According to the Final Rule (p. 73075), the 12 high volume code pairs selected by CMS account for only 30 percent of the utilization for advanced imaging codes performed in the same day for CY2010. Presumably these code pairs were reported by the same provider. This analysis is neither a random sample nor a comprehensive analysis of a majority of the services provided in the same session. Utilizing such a small and non-random analysis to validate such a broad decision is unfounded, given the severe impact it is likely to have on the imaging community, and the Medicare beneficiaries it serves every day.

The following paragraph in the Final Rule states, “Our claims analysis revealed that the majority of multiple imaging studies were for contiguous anatomic areas including thorax and abdomen/pelvis, and head/brain and neck/spine, and utilized the same modality” (p. 73075). This claims analysis is not provided, including specifically how the term “majority” was arrived at. In any event, the analysis presumably does not reflect services provided to the same beneficiary across different modalities on the same day. Including all such claims in the same analysis would increase the denominator substantially; the code pairs in Table 8 will constitute a significantly smaller percentage of same-day

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<sup>1</sup> U.S. Department of Health & Human Services. "Transparency." n.d. [HHS.gov/Open](http://www.hhs.gov/open/plan/opengovernmentplan/transparency/index.html). 1 December 2011  
<<http://www.hhs.gov/open/plan/opengovernmentplan/transparency/index.html>>.

services; and the appropriateness of generalizing these results become even less justifiable.

- **The MPPR Policy is not Precise:** On page 157 of the Final Rule, CMS stated that “An MPPR policy is not precise, but reflects efficiencies in the aggregate, such as common patient history, interpretation of multiple images involving the same patient and same anatomical structures, and, typically, same modality.” It is concerning that CMS is attempting to address efficiencies in the aggregate, when a more precise option is available in the AMA RUC process. Applying the same MPPR rule to multiple modalities, multiple body regions, code pairs that are of contiguous body regions and code pairs that are of non-contiguous body regions, simply does not make sense. The relative ease of implementing the current version of the MPPR should not outweigh the potential negative effects to quality of care and severe reduction of precision in reimbursement.
- **The MPPR Should not Apply to Code Pairs of Different Modality and/or Non-Contiguous Body Region:** All 12 of the high volume code pairs selected for CMS’ analysis are of the same modality and all are of contiguous body regions (ie 70544 MR angiography head w/o dye, 70551 MRI brain w/o dye). An analysis that is supposed to support a policy that “reflects efficiencies in the aggregate”, should also include code pairs that are of different modalities and non-contiguous body regions. If CMS decides to continue to address alleged inefficiencies with an MPPR, then a separate evidence-based MPPR percentage should be applied for each modality and then only used for contiguous body regions. The ASNR finds it troubling that CMS failed to report its methodology for identifying professional efficiencies in exams of non-contiguous body parts, where no anatomic overlap occurs; and in exams of different modalities, where pre-service, intra-service and post-service work are typically discrete and separate activities.
- **Transparency on Estimation of Redistribution:** CMS estimates that the expansion of the MPPR policy will redistribute approximately \$50 million in 2012. Please provide the methodology that was used to calculate this estimate. ASNR is concerned that this estimate is low.
- **No Peer-Reviewed Analysis Supports a Level of 25 Percent:** When two or more advanced imaging procedural codes are performed at the same time, there are little efficiency gains in the pre- and post-service periods; these gains are highly variable and substantially lower than the 25 percent reduction would imply. According to a peer-reviewed study published in the *Journal of the American College of Radiology* [Allen B, Donovan WD, McGinty G, Barr RM et al. *Journal of the American College of Radiology* – September 2011 (Vol 8, No 9, p 610-616)], *Professional Component Payment Reductions for Diagnostic Examinations When More Than One Service Is Rendered by the Same Provider in the Same Session: An Analysis of Relevant Payment Policy*, the maximum total Professional Component reduction percentage for second and subsequent services for Computed Tomography (CT) was only 2.96 percent and for Magnetic Resonance Imaging (MRI) was only 3.36 percent. The existence of these miniscule efficiencies, when services are rendered by the same provider in the same session, does not warrant an MPPR of 25 percent.

Also, with varying efficiencies coming from each code, it does not make sense to systematically apply the same 25 percent reduction to codes that have a varying proportion of pre-service and post-service time to total time. Different services have different levels of efficiency when performed during the same session. ASNR requests that CMS have the existing MPPR analysis and all future analyses reviewed by independent organizations.

- **Proposal of 25 Percent Arbitrary:** It would appear that 25 percent was arbitrarily chosen by CMS. Neither the GAO nor MedPAC made a specific recommendation to what percent the MPPR policy should use for the professional component of advanced diagnostic imaging.

**We are pleased that CMS has decided to rescind the application of the MPPR to physicians in group practice, as** there are no efficiencies when two separate physicians in the same group practice administer advanced diagnostic imaging services to the same patient. Further, the ASNR strongly supports subspecialty interpretations within group practice settings. For instance, ASNR members will typically monitor and interpret neuroimaging studies on trauma or cancer patients, while their body-imaging subspecialist colleagues will interpret exams of the chest, abdomen, or pelvis; and these radiologists may be in geographically different locations. The code pairs selected in Table 8 do not reflect this common work scenario, which maximizes throughput and maintains a high level of excellence in subspecialty management and interpretation of imaging studies performed on a single Medicare beneficiary.

As in our comment letter to the proposed rule, the ASNR continues to recommend that CMS trust the AMA RUC process. The AMA RUC valuation process is much more thorough and attuned to the impact of reimbursement policy on quality of care than an arbitrary MPPR policy could be. Instead of reflecting “efficiencies in the aggregate”, the AMA RUC process looks at efficiencies in detail. It is unfortunate that CMS no longer views itself capable of reflecting efficiencies in detail, nor trusts the AMA RUC to do so; CMS is instead now relying on clumsy and broad policies that are solely supported by a flawed analysis of only 12 code pairs. The health of Medicare beneficiaries should not be subject to such wide-sweeping and drastic policy, without a more in-depth and peer-reviewed study of the potential effects on quality and a more in-depth and peer-reviewed analysis of the actual level of efficiency gains on all potentially affected coding pairs.

The ASNR is ready and willing to share sacrifice with our physician colleagues in this challenging economic climate. The adjustability of the conversion factor in the CMS payment process exists to revise Medicare expenses in a more comprehensive manner that is understandable to all participating physicians, while maintaining the relativity of the RBRVS system that the RUC and CMS have worked so hard to establish and maintain for the past 20 years. The MPPR policy applied to the professional side distorts and marginalizes the relativity process in an unfair and as-yet-unjustified manner, at the expense largely of a single specialty.

### **CT Spine (CPT Codes 72125, 72128 and 72131)**

CT Spine codes 72125, 72128 and 72131 were originally identified in the “CMS Fastest Growing” code utilization screen through the Five Year Review Workgroup (now the Relativity

Assessment Workgroup). The ASNR was not invited by CMS to be part of refinement for these codes, even though we were one of the two presenting societies before the RUC, and had submitted a comment letter for the CY2011 Final rule that addressed these codes. We believe that without the contribution of a neuroradiologist, the panel was lacking the expertise needed to properly value the physician work for these codes. If CMS will not return to the original RUC recommended values, the ASNR requests that these codes go through a second set of refinement panels that include participants that have extensive experience performing the procedures.

We remain concerned by CMS' assertion that they "...were concerned over the validity of the survey results since the survey 25th percentile values are very close to the current value of 1.16 RVUs for the code. As we stated previously, we were concerned that this pattern may indicate a bias in the survey results." The ASNR takes this accusation seriously, and believes it baselessly calls into question the integrity of all of the societies that were involved in the surveys. The difference between the 25<sup>th</sup> percentile values and the old values of 1.16 RVUs for 72125, 72128 and 72131 was 3.45 percent. Perhaps, if a hypothetical code had an existing work RVU of 30.00 and the 25<sup>th</sup> percentile for its survey was 1.04 RVUs higher (or 3.45 percent higher) CMS would have had no issue with that situation. Comparing two values in absolute terms instead of percentage terms runs the risk of perceiving fictitious trends. Further, we find it odd that CMS is concerned about the proximity of the survey 25<sup>th</sup> percentile value (rather than the median value) to the current value of the existing code.

Assigning a value of 1.00 RVU to the spine CT codes creates new and significant rank order anomalies within the family of CT and other radiology exams. The RUC agreed at the time of the presentation that the complex segmental anatomy of the spine, the dramatic increase in images generated with modern CT scanners, and the shift in usage toward the acute post-traumatic setting argue against any decrease in existing valuation. CMS' arbitrary assignment of value disregarded many other current code valuations – something that the RUC carefully considers in its process of relative valuation. Were these repercussions considered during refinement?

In last year's final rule, CMS had decided to use the low value for all 3 codes for the interim WRVU value. After the refinement panel, 72128 and 72131 still have this same value of 1.00 RVUs. It is extremely troubling that one single individual's survey response (the lowest value returned in the work survey) was used to establish a national payment determination. If CMS had thought that the survey was invalid, why validate your decision based off of information from that same survey? The ASNR recommends that CMS use the original RUC recommended work values for 72125, 72128 and 72131, as CMS' disagreement with the RUC for these codes was based on hearsay and confirmation bias.

### **Kyphoplasty and Vertebroplasty Work Values (CPT Codes 22520-22525)**

The ASNR appreciates that CMS will not apply their site-of-service methodology of removing a half discharge day management (work RVU = 0.64) from the current (CY 2011) values in the final rule. The reason that CPT codes 22521, 22523 and 22524 were sent to refinement panel was because of CMS' original incorrect assumption that half a discharge day should be removed from the codes' valuation.

In summary: CMS initially disagreed with the RUC recommended value; next, the codes were sent to the refinement panel because of CMS' original disagreement with the RUC; and then finally CMS admitted that they were incorrect in their original reasoning for disagreeing with the RUC, but still went with the refinement panel decision. Though the ASNR trusts that CMS does not intend to use this loophole, we are concerned that unless a policy is created to eliminate this possibility, then this inefficiency will continue to proliferate.

When the reason for going to refinement panel is eliminated, what is the logic for using the refinement panel values, instead of the original RUC recommended values? The ASNR requests that CMS use the original RUC recommended work RVUs for CPT codes 22521, 22523 and 22524.

### **Conclusion**

Thank you for this opportunity to comment on the Physician Fee Schedule Final Rule. The ASNR appreciates CMS' continued collaboration with specialty societies. If you have any questions or comments on this letter, please contact James B. Gantenberg, ASNR Executive Director, at [jgantenberg@asnr.org](mailto:jgantenberg@asnr.org).

Sincerely,



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