



ASNR

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August 30, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1524-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1524-P; Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Proposed Rule

Dear Administrator Berwick:

The American Society of Neuroradiology represents 4,300 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 Proposed Rule, published on July 19, 2011.

First, we will be commenting on the Five-Year Review proposal. Next, we will provide several comments and recommendations on the proposed expansion of the Multiple Procedure Payment Reduction (MPPR) Rule to the professional component of advanced diagnostic imaging. Finally, we will discuss the proposed Radiology PQRS measures group.

Five-Year Review Proposal

In addition to the statutorily required formal Five-Year Reviews, the AMA RUC started identifying misvalued codes on an annual basis in 2009. CMS is proposing to eliminate the freestanding formal Five-Year Review process for physician work and practice expense, and to rely solely on the "Rolling Five-Year Review". ASNR is in full support of eliminating the duplicative freestanding formal Five-Year Review. ASNR believes that the elimination of the formal five-year review would provide specialty societies with moderate cost savings, which is much appreciated.

Proposed Expansion of Multiple Procedure Payment Reduction (MPPR) Rule

CMS is proposing to apply the MPPR Rule to the professional component of advanced diagnostic imaging services administered to the same patient, during the same session. This proposal is based on the assumed efficiencies in providing multiple services in the same session

due to alleged duplication of physician work, primarily in the pre-service and post-service periods. ASNR is concerned that the proposed expansion of the MPPR rule signals a developing distrust in the AMA Relative Value Update Committee (RUC) process by CMS, and that the proposed MPPR expansion is a manifestation of CMS attempting to circumnavigate the functions of the AMA RUC.

ASNR has several points that CMS should consider before deciding to implement such arbitrary and drastic payment reductions:

- **Each Image Requires Individual Interpretation:** Each set of images is unique and require individual interpretation, leaving virtually no efficiencies to be gained in the intraservice period of an image study. Radiologists are professionally and ethically obligated to expend the same level of time and effort for each image study.
- **Actual Efficiency Gains are Much Lower than 50 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 proposed 50 percent reduction would imply. According to a peer-reviewed study about to be published in the *Journal of the American College of Radiology* (available online June 29, 2011), *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 a draconian multiple procedure payment reduction of 50 percent.

Also, with varying efficiencies coming from each code, it does not make sense to systematically apply the same 50 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.

- **GAO and MedPAC Recommendations Based on Flawed Assumptions:** CMS is partially justifying the MPPR expansion proposal based on recommendations from the GAO (June 2009) and MedPAC (March 2010). The methodology that the GAO used to calculate efficiency gains was seriously flawed. The GAO counted pre-service and post-service time as having the same level of intensity as intraservice time, omitting the well-established Resource-Based Relative Value Scale (RBRVS) policy of counting intraservice work as having a higher intensity. Also, the GAO counted pre-service and post-service work as being fully duplicative, which is not the case in reality. MedPAC's recommendations are based largely on the recommendations made by the GAO.
- **MedPAC Recommended that CMS should Analyze Efficiencies and Suggested that Efficiencies May Vary by Image Type:** According to the June 2011 MedPAC report (p. 40), "CMS should calculate the payment reduction for second and subsequent professional component services performed in the same session by analyzing efficiencies

in physician work associated with multiple services. The efficiencies may vary by type of imaging.” ASNR recommends that CMS heed MedPAC’s advice and that CMS conduct an in-depth and transparent analysis before applying a blanket payment reduction to varying types of imaging. CMS should not adopt major policy changes before analyzing the potential impact they could have on the quality of care received by Medicare beneficiaries.

- **Concerns that Proposal is Influenced by Confirmation Bias:** ASNR is concerned that this policy proposal is partially based on hearsay. In addition, the GAO and MedPAC appear to be divining trends from a small sample size of carefully selected data that was selected possibly due to confirmation bias. The GAO only gave one code pair example in their June 2009 report that is cited in the proposed rule. This methodology represents a drastic departure from data-driven reimbursement policy.
- **Proposal of 50 Percent Arbitrary:** 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. It would appear that 50 percent was arbitrarily chosen by CMS. If CMS does in fact decide to apply an MPPR to the professional component of advanced diagnostic imaging, they should use a percentage that is evidence-based, instead of one that was picked arbitrarily.
- **No Data Suggesting that there are Any Efficiency Gains in Physician Liability Exposure:** Making this proposal apply to the entire Professional Component payment (which includes malpractice expense and indirect practice expenses), does not make sense, as no data exists to indicate efficiencies regarding physician’s liability exposure.
- **Duplicative Payment Reduction:** Applying the MPPR to recently valued services that have already taken into account efficiencies would be duplicative. CMS claims that their logic is validated by the recent RUC recommendations for CT of the pelvis (CPT codes 72192, 72193 and 72194) and abdomen (CPT codes 74150, 74160 and 74170), where the RUC assumed the work efficiency for the second service was 50 percent. The RUC recognizes that CT of the pelvis and abdomen are a unique example, where the services are performed together roughly 90 percent of the time. Also, the RUC recognizes that there is some duplication of intraservice work due to overlap in the imaging of these contiguous anatomic areas that is unique to this specific code pair. There is no overlap of intraservice work when different modalities are used or when body parts are non-contiguous, so using the CT of the pelvis and abdomen as rationale for applying the MPPR expansion to many of the other codes does not make sense.

For the remainder of the codes on the MPPR proposed list, the RUC has already considered other codes frequently performed in association with the indicated codes, and has already factored potential duplication of work into the recommended valuations.

CMS has indicated that they have interest in expanding MPPR even further. Some of the other ideas that are under consideration for future proposed rules are:

- Apply the MPPR to the technical component (TC) of all imaging services.

- Apply the MPPR to the professional component (PC) of all imaging service.
- Apply the MPPR to the TC of all diagnostic tests.

ASNR is against the expansion of the MPPR to any diagnostic imaging services, for the same reasons that were stated above regarding the expansion of MPPR to the professional component of advanced diagnostic imaging.

ASNR acknowledges the possibility of minor efficiency gains for some coding pairs when multiple services are rendered in the same session, but we assert that, in practice, actual efficiencies are nowhere near 50 percent for the professional component of advance diagnostic imaging procedures. The study to be published in the *Journal of the American College of Radiology* cited above estimated that the arithmetic mean true impact on the professional component for CT was 2.96 percent and for MRI's was 3.36 percent.

Instead of implementing this excessive and arbitrary proposal, ASNR recommends for CMS to continue to trust the AMA RUC process. The AMA RUC valuation process is much more thorough and attune to the impact of reimbursement policy on quality of care. The health of Medicare beneficiaries should not be subject to such wide-sweeping and drastic policy, without a more in-depth study of the potential effects on quality and a more in-depth analysis of the actually level of efficiency gains on all potentially effected coding pairs.

Radiology PQRS Measures Group

ASNR welcomes the proposed *Radiology Measures Group*, though we also have several recommendations. We would suggest that CMS use a more specific name for the measures group though, as the name, "Radiology Measures Group", is vague and implies that there will not be additional radiology measures groups in the future. Perhaps a name along the lines of "Radiology Appropriateness, Utilization and Exposure Measures Group" would be more appropriate.

ASNR questions the size of the proposed measures group. The *Radiology Measures Group* is comprised of 10 individual measures, making it tied (with two other proposed measures groups) for being largest proposed measures group, out of 24 total proposed groups. Without seeing the specifications, which are not final until December 31, 2011, ASNR is concerned that neuroradiologists will not be able to use the measures group. We recommend that the proposed measures group be split in to two smaller, more specific, measures groups.

ASNR believes that the flexibility of PQRS measures is vital to the success of the PQRS program. We recommend that each individual measure that comprises the *Radiology Measures Group* also be a stand-alone measure that can be individually reported.

Also, during CMS' AMA Briefing on August 2, 2011 on the quality portion of the proposed rule, a CMS staffer had mentioned that the primary reason for only allowing the reporting of some PQRS measures groups and individual measures only by registry-based method, was because the claims-based method required the creation of CPT Category II codes. This was quickly refuted by an AMA staffer, stating that the registry method also required the creation of CPT Category II codes. ASNR requests that the *Radiology Measures Group* be reportable by the claims-based

method, as well as the registry-based method, to give access to this group measure to radiologists who do not have access to a registry.

PROPOSED MEASURES INCLUDED IN THE PROPOSED 2012 RADIOLOGY MEASURES GROUP*

Physician Quality Reporting System Number	Measure Title	NQF Measure Number	Measure Developer
TBD	Reporting to a Radiation Dose Index Registry	N/A	
TBD	Cumulative Count of Potential High Dose Radiation Imaging Studies: CT Scans and Cardiac Nuclear Medicine Scans	N/A	ABMS/ABR/ACR/PCPI
TBD	Utilization of a Standardized Nomenclature for CT Imaging Description	N/A	ABR
TBD	Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules According to Recommended Guidelines	N/A	ABR
TBD	Overuse: Abdomen, Pelvis or Combined Abdomen/Pelvis CT Studies	N/A	ABR
TBD	Equipment Evaluation for Pediatric CT Imaging Protocols	N/A	ABR
TBD	Utilization of Pediatric CT Imaging Protocols	N/A	ABR
TBD	Search for Prior Imaging Studies through a Secure, Authorized Media-Free Shared Archive	N/A	ABR
TBD	Images Available for Patient Follow-up and Comparison Purposes	N/A	ABR
TBD	Exposure Time Reported for Procedures Using Fluoroscopy	N/A	PCPI/ACR/ NCQA

* This measures group is reportable through registry-based reporting only.

Conclusion

Thank you for this opportunity to comment on the Physician Fee Schedule Proposed Rule. ASNR firmly believes that efficient channels of communication between specialty societies and CMS are critical to the continued improvement in the quality of care that Medicare beneficiaries receive and to intelligently reducing the burden of rapidly growing health care costs on the United States government and economy. 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.

Sincerely,

A handwritten signature in black ink that reads "David B. Hackney". The signature is written in a cursive, flowing style.

David B. Hackney, MD, FACR
President
American Society of Neuroradiology

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