January 27, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1601–FC
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals; Final Rule

Dear Administrator Tavenner:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) final rule on Hospital Outpatient Prospective Payment (HOPPS) and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.

The ACR provides comment on the following important issues:

1) Implementation of the CT and MR Cost Centers Cost-to-Charge Ratio (CCR) Data

2) Establishing Comprehensive Device-Dependent Ambulatory Payment Categories (APCs)

3) Placement of the Breast Biopsy Codes in APC 0005

4) Placement of Abscess Drainage Codes in APC 0006 and 0685

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

Implementation of CT and MR Cost Center Data

For 2014, CMS has implemented the use of the FY 2012 cost data to establish separate cost-to-charge ratios (CCRs) for CT and MR, distinctly separate from the general radiology CCR, for determining APC weights. CMS attempted to address concerns by many stakeholders that the data was inaccurate by removing claims data from hospitals that used the "square feet" cost allocation method. CMS is adopting this change for four years, 2014-2017, and believes that this is sufficient time to use one of the more accurate cost allocation methods. Beginning in 2018, CMS will estimate the CT and MRI APC relative payment weights using cost data from all providers, regardless of the cost allocation statistic used.

The ACR still strongly opposes this proposal and requests that CMS not move forward with this policy and that the policy does not continue during the 4 year grace period. ACR concludes that the significantly lower CCRs for CT and MR (compared to the CCR for general radiology) lack face validity and should not be used for payment purposes for the following reasons.

- During an era where CMS is moving towards further bundling, e.g. comprehensive device-dependent APCs, this policy requires hospitals to focus on creating more granular data for targeted technologies instead of understanding the economics of broader bundles. The policy of isolating a technology widely used across a broad spectrum of episodes of care runs counter to the thrust of HOPPS policy to pay for broader packages of services.
- This policy reduces the cost of only these selected technologies within a wide range of services. The point of packaging services into APCs is to encourage efficiency by the hospital, which may or may not lie in the costs of these technologies.
- While the policy is being phased in, CMS will be excluding a large volume of claims from the rate-setting process in order to select those claims that meet this policy's requirements. Excluding major claims volume from rate setting runs counter to HOPPS policy to use the maximum volume of claims available.
- Creating cost centers for CT and MR technologies targets these technologies for specialized cost accounting by hospitals and causes further administrative burden. CMS should reconsider the impact of this policy before adopting and provide evidence that there is no negative impact before continuing to implement in future years.
- The recommendations by the Research Triangle Institute in 2007 are outdated and were made at a time when CMS was not extensively bundling services for payment in HOPPS. The justification for imposing this burden on hospitals and

targeting CT and MR technologies is not clear, beyond the findings from the original RTI report, which did not focus on a wide range of medical technologies.

Other Consequences

CMS' decision to move forward with this policy is having a significant impact not only on hospitals but also in other policies and payment systems. An important consequence of this policy is the impact on the technical component of CT and MR codes in the Physician Fee Schedule (PFS): separate CT and MR CCRs results in HOPPS technical payments falling below the PFS payment rates causing further PFS payment cuts as mandated by the Deficit Reduction Act of 2005 (DRA). As shown in the table below, CT without contrast studies suffer approximately a 23% reduction in FY 2104 as a result of this CT and MR HOPPS policy. The rippling effect of HOPPS payment rates on physician office services heightens the importance of ensuring that any changes made to the HOPPS methodology are fully justified and are based on correct data This is not simply a matter of ensuring that hospitals will be appropriately reimbursed. Physician offices are unlikely to have the volume and mix of patients treated by a typical hospital. CMS must be conscious of and explain the entire impact of payment changes in cases where HOPPS rates affects payment rates in other payment systems.

CPT	Description	2013 NF* Pay (DRA cap does not apply)	2014 NF Pay after DRA cap	Change in NF Pay 2013-2014	% Change 2013-2014
70490	Ct soft tissue neck w/o dye	$163.65	$126.45	$-37.20	-22.7%
71250	Ct thorax w/o dye	$163.99	$126.45	$-37.54	-22.9%
72125	Ct neck spine w/o dye	$166.37	$126.45	$-39.92	-24.0%
72128	Ct chest spine w/o dye	$165.35	$126.45	$-38.90	-23.5%
72131	Ct lumbar spine w/o dye	$164.67	$126.45	$-38.22	-23.2%

CT and MR services have endured 12 cuts since 2006, the majority of which have been applied to the technical component (TC). In addition, another 10% TC cut took place with the implementation of the 90% equipment utilization rate as mandated by the Taxpayers Relief Act for CY 2014. Additional payment reductions will make these studies non-viable in the office setting since physician offices will be unable to cover the costs necessary to provide these services, under even the most cost-efficient scenario.

Technical Comments

In the Final 2014 HOPPS Rule, CMS introduced an interim method to calculate rates while hospitals work to convert to more accurate cost allocation methods. The new methodology excludes single claims for hospitals that use "square foot allocation" methods in cost reporting for CT/MR cost centers. The final rule describes the expected impact of its proposed methods on rate setting, specifically in Tables 3, 4 and 5 in the final rule. However, the description of the methodology used for these calculations is insufficient. ACR's consultants from The Moran Company found it impossible within the 60-day comment period, to replicate CMS' results. Since they cannot replicate CMS' results we cannot comment on either how CMS should remedy the level of cuts to the rates in 2014 or comment on details of methodology.

CMS presented three findings in the final rule. Table 3 in the final rule showed the magnitude of the cuts given the implementation of the new CT/MR cost centers and is the same table included in the proposed rule. Table 4 showed how much larger the cut could have been had it not excluded square foot allocating providers. Table 5 shows the different average values of CT and MRI cost centers based on different cost reporting methods. None of the data in these tables explain exactly how CMS generated the geometric mean values in the final rule.

Moran's attempts to replicate CMS' policy, including the removal of claims from providers that used a cost allocation method of the square foot (SF) to calculated CCRs were not successful due to lack of detail in the rule. CMS does not indicate the year of the cost reports they used to determine the providers to be removed; it appears that the 2011 cost reports may have been used but this can only be assumed. In other rule making practices, CMS uses the most recent cost report and only goes back to the prior year's cost report if the most recent one is not available. CMS may also make determinations based on the characteristics of the cost report (e.g., partial year), but again does not explain the approach used for this analysis. CMS mentions two different worksheets to check, and lists four combinations of providers (SF Allocators, Direct Allocators, Dollar Value Allocators, and Direct + Dollar Value allocators) but the specific situation where providers who use square foot allocation in combination with direct allocation are not addressed. As a result, our consultants are uncertain how to treat the cost reports for these hospitals.

Moran's replication of the removal of SF allocators showed a volume of single claims comparable to what CMS reports for the CT and MR codes. However, their calculations were not close to the geometric mean costs. Instead, the Moran calculations are usually 10-20% lower than CMS' published data. When comparing the geometric means after removing the SF allocators to the geometric means calculated before removing them, Moran gets unanticipated results:

- Many codes have DECREASED average costs when removing SF allocating hospitals; and

- Those codes with increases are not limited to low volume codes.

Most mean costs move only 1-2% up or down when the impact of removing the SF allocators is allocated – not close to what CMS reported in table 4.

Recommendation:
The ACR recommends that CMS not implement this policy because of severe data limitations. We do not believe that more time and experience with the new cost centers will lead to improved data even with the exclusion of the square feet cost allocation method; it is our experience that hospitals vary widely on how they report their charges and costs. We believe it would be best to maintain a single diagnostic radiology cost-to-charge ratio, given the difficulties that hospitals have in accurately accounting for their radiology-related costs, especially on a more granular basis.

Establishing Comprehensive APCs

CMS also decided to move forward with the development of the 29 comprehensive device-dependent ambulatory payment categories (APCs). Seventeen of these now are categorized as complex. Because of grave concerns that CMS has not provided adequate time or data for stakeholders to replicate the methodology and verify that all data are being captured, CMS has also delayed implementation of the final configuration of those comprehensive APCs until CY 2015 and is soliciting comments.

CMS has presented the theoretical framework for this new episode-of-care-like APC. The ACR offers the following observations for your consideration:

- Since CMS is using the device dependent procedures to test the comprehensive APC model, it will be important to recognize that expansion of the device dependent policy to other major procedures may not have the same profile of costs.
- The basic idea underlying the comprehensive APC is that all of the services on a single outpatient claim are assumed by CMS to be related to one major procedure. It is unclear what happens to data on a claim that is not related. At present there are no policies to exclude any codes or costs from these comprehensive APCs. CMS should be mindful of including only codes and costs that are related and then make decisions about what to do with the unrelated costs. Ideally unrelated studies should be separately paid and their data used in rate setting whenever possible.
- If the procedures inside and outside the comprehensive APCs have different cost profiles, removing those in the comprehensive APCs from rate setting could bias rate setting for those that remain outside. This will only be important where the volume outside the comprehensive APCs is significant.

- CMS does not provide any "payment adequacy" analysis of the resulting geometric means used as the basis for payment rates, in relation to the device intensive costs of these claims. This information may be necessary to determine whether or not some of the complex comprehensive APCs need to be split into additional APCs since 50-90% of a device-dependent procedure is the device cost. When multiple device-dependent procedures are put together in an APC and then averaged, the payments for some combinations may not be enough to cover the cost of the device itself. This would create an inequity within a comprehensive APC that would need to be addressed.

Recommendation:

The ACR would like to work with CMS on analysis of the device-dependent Comprehensive APCs, especially since there are two, APC 0083 and 0229, that account for 83% of all the packaged imaging cost included in the 29 comprehensive APCs. Both Coronary Angioplasty, Valvuloplasty, and Level I and Level II Endovascular Revascularization of the Lower Extremity are designated as complex cases. The ACR would like to insure moving forward that all imaging data is being captured correctly and that there are adequate payment levels for the device-dependent comprehensive APCs. It is important to establish this base before this policy is implemented and possibly expanded in the future.

Placement of the Breast Biopsy Codes in APC 0005

In the final rule, CMS place the new bundled breast biopsy codes (19081, 19083 and 19085) into APC 0005. On October 21, 2013 the ACR met with CMS and recommended that these three separately paid codes be mapped to APC 0037 (Level IV in the same series). The simulation below, which we shared with you at our meeting, shows that these codes are not appropriate for APC 0005. In addition, as listed below, the profile of codes in APC 0037 demonstrates that assignment of these codes to APC 0037 is a better fit. Codes 19081, 19083 and 19085 should remain together in the same APC because of their clinical homogeneity. These codes all represent a biopsy of the breast, with placement of breast localization device(s), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion. The only difference is the type of guidance used when performing the biopsy (stereotactic, ultrasound or MR guidance). Further, these codes should all be in the same APC because there should be no payment incentive for hospitals to provide one type of breast biopsy guidance over another type of imaging guidance. Hospitals should use the method that is the most clinically appropriate and the most cost effective.

Simulation of New Codes 19081-19086 Breast Biopsy

New Code	Predessor Codes	Status Indicator	Current APC Assignment	Geometric Mean For APC 0005	Total Frequency	Singles	Median Cost	Mean Cost	Geometric Mean Cost
19081	77031 + (19102 OR 19103) + (19290 OR 19295)	T	0005	$704.54	32,739	29,659	$1,017.13	$1,212.90	$1,013.37
19082	77031 + (19102 OR 19103) + (19291 OR 19295)	N			-	-	$ -	$ -	$ -
19083	76942 + (19102 OR 19103) + (19290 OR 19295)	T	0005	$704.54	39,698	30,975	$ 866.24	$1,074.62	$ 897.94
19084	76942 + (19102 OR 19103) + (19291 OR 19295)	N			*	*	*	*	*
19085	77021 + (19102 OR 19103) + (19290 OR 19295)	T	0005	$704.54	1,493	1,024	$1,521.25	$1,728.51	$1,456.85
19086	77021 + (19102 OR 19103) + (19291 OR 19295)	N			-	-	$ -	$ -	$ -

2014 Profile of APC 0037 (new codes CMS assigned are in red)

HCPCS Code	Short Descriptor	SI	APC	Payment Rate	Single Frequency	Geometric Mean Cost
49405	Image cath fluid colxn visc	T	0037	$1,223.25	-	$ -
49406	Image cath fluid peri/retro	T	0037	$1,223.25	-	$ -
54500	Biopsy of testis	T	0037	$1,223.25	3	$ 1,947.22
19103	Bx breast percut w/device	D			49,390	$ 1,238.41
44901	Drain app abscess percut	D			19	$ 1,380.02
47011	Percut drain liver lesion	D			393	$ 907.48
48511	Drain pancreatic pseudocyst	D			44	$ 943.06
49021	Drain abdominal abscess	D			1,267	$ 1,127.56
49041	Drain percut abdom abscess	D			62	$ 1,007.19
49061	Drain percut retroper absc	D			619	$ 951.19
50021	Renal abscess percut drain	D			162	$ 1,009.14

Ideally this change would be made for 2014 since ACR did provide input when the final rule was being drafted. We are aware that a manufacturer recently sent a letter to CMS requesting a technical correction of the APC placement of the new bundled breast biopsy codes. The ACR supports this request and feels that it is consistent with what ACR has previously analyzed and requested - placement of these codes into APC 0037.

Recommendation:
CMS reassign breast biopsy codes 19081, 19083 and 19085 into APC 0037 for 2014. This is supported by information ACR provided before the final rule was published.

Abscess Drainage Codes

During ACR's meeting with CMS last October, ACR made a clinical argument and recommended that codes 10030 & 49405, 49406 and 49407 be treated as a clinically coherent group of codes and all should be assigned to APC 0037. CMS assigned only two of the codes to APC 0037 (codes 49405 and 49406). CMS assigned code 10030 to APC 0006 (incision and drainage), and assigned code 49407 to APC 0685. The ACR maintains that all four codes in this family should be assigned to the same APC since the resources involved in providing these services are identical. The codes are only differentiated by the anatomic location of the placement. Below is a simulation of the new codes using the 2012 data from their predecessor codes showing similarity in the median costs of the predecessor codes. Importantly, code 10030 had no specific predecessor code as no code existed specific to subcutaneous drainage catheter placement. The code used in our simulation, code 10140 likely underestimates actual cost, further supporting our recommendation that all four codes be included in the same APC 0037.

Simulation of New Codes 10030 & 49405-7 Abscess Drainage

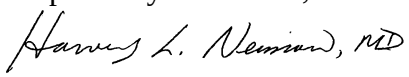
New Code	Predessor Codes	Status Indicator	Current APC Assignment	Geometric Mean For APC	Total Frequency	Singles	Median Cost	Mean Cost	Geometric Mean Cost
10030	75989 + 10140	T	0006	$160.22	248	200	$ 880.94	$ 1,073.50	$ 918.51
49405	75989 + (32201 OR 48511 OR 47011 OR 50021)*	T	0037	$1,227.53	527	383	$ 1,015.86	$ 1,152.12	$ 1,008.20
49406	75989 + (44901 OR 49021 OR 49041 OR 49061)	T	0037	$1,227.53	2096	1,499	$ 1,151.85	$ 1,334.85	$ 1,156.58
49407	75989 + 58823	T	0685	$760.41	65	52	$ 1,209.27	$ 1,352.88	$ 1,185.73

Recommendation:
The ACR requests that CMS move codes 10030 and 49407 to APC 00037. The ACR believes that the data shows that all of the abscess drainage codes should continue to be together in one clinically cohesive group.

Conclusion

Thank you for the opportunity to comment on the CY 2014 Final Rule. If you have any questions about our comments please feel free to contact Pam Kassing at 800-227-5463 ext. 4544 or via email at pkassing@acr.org.

Respectfully Submitted,



Harvey L. Neiman, MD, FACR
Chief Executive Officer

cc: Liz Richter, CMS
Marc Hartstein, CMS
Marjorie Baldo, CMS
Erick Chuang, (cost centers)
Ann Marshall, CMS (packaging)
James Poyer, CMS (PQRS)
Geraldine McGinty, MD, MBA, ACR
Zeke Silva, MD, ACR
Pam Kassing, ACR