RBMA
Radiology Business
Management Association

January 27, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1600-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8013

Subject: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

The Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) final rule on the revisions to payment policies under the Medicare Physician Fee Schedule (MPFS) for CY 2014 as published in the December 10, 2013 *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

Since 2006, Medicare's payments to imaging have been cut at least 12 times; nine of these have directly targeted the technical component. Total cuts to CT's technical component (TC) alone are in the range of 40 to 55 percent as of 2012.[1] Payment cuts continue in 2014 in the form of Medicare's 90 percent equipment usage rate assumption and new interests rates for capital costs from the Small Business Administration (SBA). Less well known but more dramatic are new equipment time estimates for select, but high-volume, CT and MRI services, most notably CT brain and MRI brain. For example, last year code 70450 (CT brain without contrast) had a national technical component Medicare payment of $167.39. Using 2013's Medicare conversion factor ($34.023) in order to control for the 0.5 percent update approved by Congress and various budget neutrality adjustors, code 70450 would have a TC Medicare payment of $77.57 in 2014 for a cut of nearly *54 percent* in one year.

RBMA is concerned about the general downward trend in Medicare payments for imaging services. These cuts will have a profound impact on freestanding imaging centers in the

[1] Neiman Report, Brief 01, October 20, 2012, "Medical Imaging: Is the Growth Boom Over?", page 2, Harvey L. Neiman Health Policy Institute, American College of Radiology

form of staff lay-offs, salary reductions, and possible closures as they attempt to absorb such large revenue reductions in one year. Two examples are worth noting:

- A radiology practice in central Pennsylvania plans to lay-off at least 10 percent of its employees in the face of a nearly 38 percent cut in their MRI and CT payments under Medicare. These layoffs will have a profound effect on this practice's ability to provide patients in this region with advanced imaging in addition to the potential for patient safety issues that increase when there are staff reductions.
- Insight Imaging closed five imaging centers in Arizona in the last year because of Medicare's payment cuts, some of which had significant Medicaid patient volume, causing access issues for Medicare and Medicaid patients along with other patients in this area.

Needless to say, these effects will, in turn, create 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 relative values.

Comments on Specific Issues in the Final Rule

CY 2014 CPT Codes Subject to 90 Percent Usage Rate (*Federal Register page 74238*)

RBMA understands that, as a result of the America Taxpayer Relief Act of 2012 (ATRA), CMS is compelled to apply the 90 percent usage rate assumption to MR and CT services in CY 2014 and subsequent years. Yet, we continue to maintain that a 90 percent equipment usage assumption for CT, MRI, or any other imaging modality for that matter is arbitrary and inconsistent with standard practice in freestanding (non-hospital) imaging centers. Repeatedly, RBMA has made the case that:

1. MedPAC's 90 percent equipment rate assumption represents a normative standard that is unrealistic and based on flawed information.
2. CMS' previous efforts to implement a 90 percent usage rate assumption were based on insufficient evidence and failed to meet the requirement of the Balanced Budget Act of 1997 (BBA) that resource-based relative values reflect actual and complete cost data.
3. Per its own research:
   - Utilization rates for imaging modalities overall were consistent with Medicare's 50 percent usage rate
   - Utilization rates for "advanced imaging" (e.g., CT, MRI) are closer to a 60 percent rate than the 90 percent utilization normative standard recommended by MedPAC
   - Rural imaging centers had lower utilization rates than non-rural centers, making them more financially vulnerable to an arbitrarily excessive increase in the utilization rate
4. "Real world" scheduling demands (e.g., lunch and other breaks, irregular exams, emergency exams, maintenance, weather, breakdowns, and "no shows") make achieving a 90 percent utilization rate nearly impossible, even in the busiest centers, and certainly not representative of the norm.

Interest Rates (*Federal Register page 74239*)

CMS finalized basing the interest rates used in calculating equipment costs on sliding rates from Small Business Administration (SBA). RBMA points out those SBA interest rates are intended to incentivize loans to small businesses and may not reflect the true cost of capital since this results in high-cost equipment like MRI and CT having the lowest interest rate under CMS' methodology. The relentless and often unsupported cuts to imaging reimbursements have increased the bank's risk when loaning money to buy high technology imaging equipment which has driven rates higher, not lower.

Using HOPPS and ASC Rates in Developing Practice Expense (PE) Relative Value Units (RVUs) (*Federal Register page 74246*)

CMS decided appropriately not to finalize its proposal to use HOPPS and ASC rates to cap practice expense relative value units (PERVUs) in the non-facility setting. RBMA reminds CMS that: (1) hospitals and health systems enjoy cost advantages derived from their purchasing power relative to non-facilities such as physician offices, freestanding imaging centers, and independent diagnostic testing facilities (IDTFs) and (2) hospital outpatient prospective payment system (HOPPS) rates may not be comparable to PERVUs because of the varying methodologies hospitals utilize to report their direct costs.

Multiple Procedure Payment Reduction (*Federal Register page 74261*)

RBMA appreciates CMS' decision not to finalize any new multiple procedure payment reduction (MPPR) policies for CY 2014. We understand that the agency continues to look at expanding the MPPR based on efficiencies when multiple procedures are furnished together. RBMA has expressed concern that MPPR policies to date reflect inflated multiple procedure efficiencies and, before considering further MPPR expansion, evidence supporting new MPPR policies should be made available to the public.

Interim Final Work RVUs for New/Revised/Potentially Misvalued Codes (*Federal Register page 74323*)

New CPT Codes for Breast Interventions (19081-19086; 19281-19288)

CY 2014 Medicare payment rates associated with the new bundled CPT codes for breast biopsy and other minimally-invasive services represent a significant departure from rates in place as recent as last year. Dr. Ezequiel Silva III, vice-chair of the American College of Radiology's (ACR) Commission on Economics and the ACR's advisor to the RVS Update Committee (RUC), estimates an average 24 percent reduction to the professional component and a 17 percent reduction to the technical component across the code family.[2] In the same article, he writes,"[s]tereotactic biopsy alone is now reduced by 45 percent for the professional component and 3 percent for the technical component." Vacuum-assisted biopsy, previously reported using CPT code 19103, has seen its payments cut by an estimated 30 percent. RBMA is concerned that Medicare payment cuts of this magnitude will have unanticipated consequences on patients' access to these services and the locations where these services are provided.

[2] *Journal of the American College of Radiology* (Vol. 11:1, pp. 80-81)

Establishing Interim Final Direct PE RVUs for CY 2014 (*Federal Register page 74343*)

Equipment Time for CT and MRI of the Brain and Spine

Equipment time, thus equipment cost, is the largest contributor to direct expenses (practice expense RVUs) for advanced imaging such as CT and MRI. As the table below depicts for CT and MRI of the brain and spine, CMS greatly reduced its equipment time estimates for CY 2014 which results in dramatically lower TCRVUs for the affected procedures. As mentioned in our general comments, payment cuts this severe and to such high-volume services are creating serious problems for freestanding imaging centers.

				Difference 2014 vs. 2013 (%)	
Code	**Descriptor**	**2014 Equipment Time**	**2013 Equipment Time**	**Equipment Time**	**TCRVUs***
70450	CT head/brain w/o dye	17	26	-34.6	-38.4
70460	CT head/brain w/dye	24	34	-29.4	-34.8
70551	MRI brain stem w/o dye	31	68	-54.4	-55.3
70552	MRI brain stem w/dye	45	70	-35.7	-42.0
70553	MRI brain stem w/o & w/dye	53	82	-35.4	-41.8
72141	MRI neck spine w/o dye	31	58	-46.6	-47.9
72142	MRI neck spine w/dye	45	70	-35.7	-42.1
72146	MRI chest spine w/o dye	31	58	-46.6	-48.0
72147	MRI chest spine w/dye	45	60	-25.0	-33.3
72148	MRI lumbar spine w/o dye	31	58	-46.6	-48.0
72149	MRI lumbar spine w/dye	45	70	-35.7	-41.8
72156	MRI neck spine w/o & w/dye	53	80	-33.8	-40.4
72157	MRI chest spine w/o & w/dye	53	72	-26.4	-34.4
72158	MRI lumbar spine w/o & w/dye	53	80	-33.8	-40.4

*The TCRVU impacts include other policy changes (e.g., usage rate, interest rates), if applicable.

Unlike major policy initiatives, changes to CMS RVU inputs go largely unnoticed in the final rule by providers and their impacts felt only when actual payment rates are published or used in paying claims. **RBMA offers two recommendations to improve transparency: (1) CMS should publish its decisions on inputs on a more timely basis (e.g., quarterly, following meetings of the RVS Update Committee) and (2) the interim values will not be used for payment purposes until the following year.** RBMA believes these recommendations would afford providers time to make the necessary financial decisions and collect data in response to the interim values.

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Issue for the 2015 Medicare Fee Schedule Proposed Rule

RBMA recommends that Medicare cover percutaneous needle breast biopsies performed in independent diagnostic testing facilities (IDTFs).

RBMA requests that CMS revise its current coverage policies to expressly allow IDTFs to bill the Medicare program for percutaneous needle breast biopsies and related procedures: (1) pursuant to an order from the patient's treating physician and (2), if the IDTF provides evidence of its Mammography Quality Standards Act ("MQSA") certification, or alternatively, to permit IDTFs to dually enroll as both IDTFs and physician offices for the sole purpose of performing percutaneous needle breast biopsies.

Percutaneous needle breast biopsies are diagnostic procedures performed for the purpose of diagnosing disease, and are appropriate for the IDTF setting. In addition, IDTFs offer a more cost efficient place of service than hospital outpatient departments. Our request for coverage has been made more acute with the new CPT codes for breast interventions (19081-19288) which include imaging guidance. With the new codes, IDTFs may not be able to bill and be paid for any imaging services associated with the biopsy.

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The RBMA appreciates the opportunity to comment on CMS' CY 2014 Medicare Physician Fee Schedule final rule. 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,

Wendy Lomers, MBA, CPA
President, RBMA Board of Directors

cc: Marc Hartstein, CMS
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