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October 1, 2020

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1736-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician-owned Hospitals

Dear Administrator Verma:

The American College of Radiology (ACR), representing nearly 40,000 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) proposed 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. Proposed Calculation and Use of Cost-to-Charge Ratios (CCRs)
2. Proposed Ambulatory Payment Classification (APC) Placement of New and Revised calendar year (CY) 2021 Category I and III CPT Codes
3. Proposed APC Placement of Cardiac Computed Tomography (CT) Current Procedural Terminology® (CPT) Codes
4. Proposed APC Placement of Cardiac Magnetic Resonance (MR) CPT Codes
5. Proposed APC Placement of Single-Photon Emission Computed Tomography (SPECT) CPT Code

### **Proposed Calculation and Use of Cost-to-Charge Ratios (CCRs)**

#### *Proposal*

Beginning in CY 2021, CMS proposes to fully implement the CT and MR cost data regardless of the cost allocation method.

**HEADQUARTERS**  
1891 Preston White Drive  
Reston, VA 20191  
703-648-8900

**GOVERNMENT RELATIONS**  
505 Ninth St. N.W.  
Suite 910  
Washington, DC 20004-2173  
202-223-1670

**CLINICAL RESEARCH**  
1818 Market Street  
Suite 1720  
Philadelphia, PA 19103-3604  
215-574-3150

**AMERICAN INSTITUTE FOR  
RADIOLOGIC PATHOLOGY**  
1100 Wayne Ave., Suite 1020  
Silver Spring, MD 20910  
703-648-8900



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### *ACR Perspective and Comments*

The ACR *requests that for the CY 2021 HOPPS final rule, that CMS set weights based on a single diagnostic radiology CCR—the same policy that CMS applied before it created separate CT and MRI standard cost centers in 2011.* The ACR makes this request based on evidence that the CCRs for CT and MRI data is flawed and are causing hospital payments for CT and MRI services to be too low.

In February 2018, the ACR met with CMS officials and recommended the elimination of CT and MRI standard cost centers from both the Inpatient Prospective Payment System (IPPS) and HOPPS and to return to the exclusive use of the diagnostic radiology CCR. The ACR makes this request because of evidence that the original intent for the CCRs for CT and MRI to help eliminate charge compression within the imaging APCs is not being met. The ACR has addressed our concerns in previous rulemaking comments.

### *Rationale for Separate Hospital Reporting of CT and MRI Cost Centers*

CMS’s policy on this issue was raised in the FY 2009 HOPPS rule where it discussed “a contract [awarded] to the Research Triangle Institute (RTI) to study the effects of charge compression in calculating the relative weights and to consider methods to reduce the variation in the CCRs across services within cost centers.”<sup>1</sup> Charge compression describes higher percentage mark-ups on low cost items than high cost items. Using a single CCR that groups low and high cost items will result in underpayment of the high cost item and overpayment of the low-cost item. While RTI’s study was largely undertaken because of concerns about high cost medical devices being reported in the same cost center as low-cost supplies, RTI’s analysis went beyond that narrow issue.

For MRI and CT, the charge-compression hypothesis would set out to determine if higher cost diagnostic tests like MRI and CT have lower percentage mark-ups than lower cost X-ray tests. While MRI and CT scans are more expensive than traditional X-rays, the results of creating separate cost centers for them has produced the opposite result than would be expected—higher mark-ups for the more expensive services than the less expensive services. As this result is the opposite of the hypothesis, the hypothesis is false. However, it does not mean that the opposite is true—that MRI and CT have lower percentage mark-ups than other diagnostic X-ray tests. As the results are counter-intuitive, it makes more sense to conclude that how costs are reported to these costs centers is problematic than it does to conclude that CT and MRI are overvalued with a single radiology CCR.

Indeed, public comments acknowledged by CMS on this issue suggest the data is problematic:

The commenters believed that the CCRs for advanced imaging may reflect a misallocation of capital costs on the cost report. They further stated that this could indicate that many hospitals are reporting CT and MRI machines as fixed equipment and allocate the related capital costs as part of the facility’s

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<sup>1</sup> Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, Final Rule, August 19, 2008, page 48451.

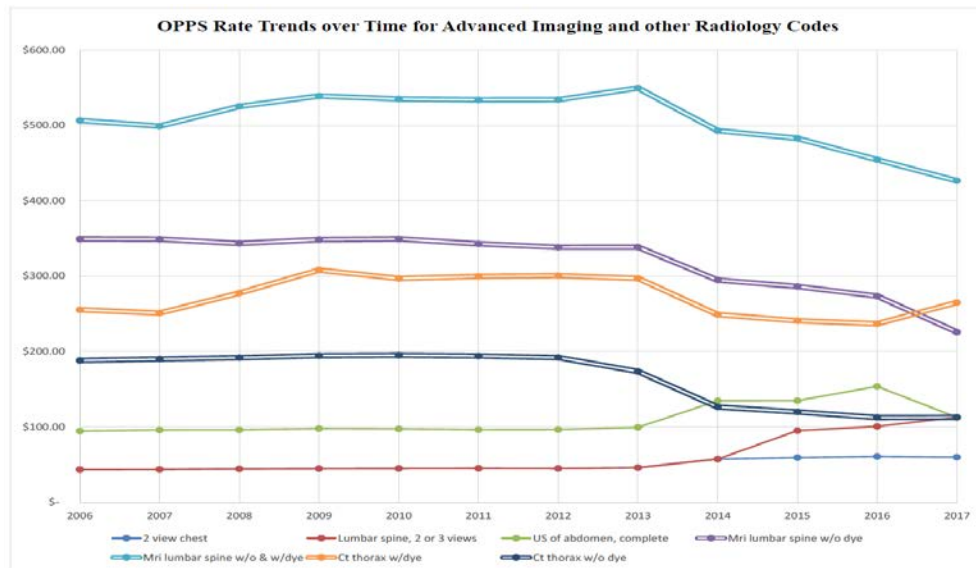
Building and Fixtures overhead cost center instead of reporting the capital costs directly in the Radiology cost center.<sup>2</sup>

In responding to commenters’ statements that hospitals would have problems with accurate creation of these new standard cost centers, CMS acknowledged that the allocation of very high cost “moveable equipment” to the department using that equipment, may not be a standard practice in hospitals. CMS recognized that such practice would not produce accurate CCRs and, it is for this reason that CMS delayed use of some hospital CCRs to set HOPPS rates until CY 2020.

*Policy Impact of Separating CT and MRI Cost Centers*

Figure 1 below illustrates the trajectory of selected single procedure HOPPS rates for advanced and non-advanced imaging procedures. The CCRs for CT and MRI cost centers are inaccurate and too low and are depressing the valuation of APCs that include CT and MRI. The rate in CY 2017 under the HOPPS for CT thorax w/o dye is now the same as that for an ultrasound of the abdomen complete and for an X-ray of the lumbar spine 2-3 views. These are all high-volume procedures, and advanced and non-advanced imaging are being paid at the same levels. Other high volume advanced imaging procedures have rates moving in the same direction. This pattern of payment does not fit the hypothesis of “aggregation bias” described by RTI based on 2007 data. On the surface, it does not make sense to pay the same for a CT as an ultrasound or an X-ray when a CT scanner is far more expensive than the ultrasound or X-ray equipment.

**Figure 1.** Trends in Rates for Selected Imaging Procedures: Advanced and Non-Advanced



*The Problem is Getting Worse, Not Better*

<sup>2</sup> FY 2009 IPPS Final Rule, page 48456.



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In the chart below, we show the hospital level billing practices for selected CT and MRI claims. These data show that only about half of all hospitals paid under the HOPPS had CT and/or MRI cost centers that were reporting CCRs using the preferred methods (“dollar value” or “direct assignment”). Hence current rates have declined based on using partial data. When all data are used for the CY 2021, it is unlikely that more hospitals will have changed their cost reporting to the method preferred by CMS. Even if they did, the CCRs for CT and MRI using the other cost allocation methods also appear to be unreasonably low as we detail further below. In short, regardless of cost allocation method, separate CCRs and cost reporting for MRI and CT appear to be inaccurate.

The data in Chart 1 shows that hospitals have either been unable or unwilling to make the changes CMS regulations mandated.

HCPCS	Short Descriptor	Total Number of Hospitals	Number of Hospitals with MR or CT Cost Centers	Percent of Hospitals with MR or CT Cost Centers	Number of Hospitals with MR/CT Cost Centers Using Non-Square Footage Allocation Method	Percent of Hospitals with MR/CT Cost Center using Non-Square Foot Allocation Method	Geomean Cost of Total Hospitals	Geomean Cost of Hospitals with MR/CT Cost Centers Using Non-Square Footage Allocation Method	Percent Difference Between All Hospitals and Hospital Correctly Complying with CMS MR/CT Cost Center Billing
70553	Mri brain stem w/o & w/dye	2,926	2,020	69.0%	1,467	50.1%	\$ 380.51	\$ 335.76	-7.4%
71250	Ct thorax w/o dye	3,187	2,145	67.3%	1,541	48.4%	\$ 97.89	\$ 80.86	-21.1%
71260	Ct thorax w/dye	3,074	2,114	68.8%	1,519	49.4%	\$ 125.59	\$ 100.39	-25.1%
72148	Mri lumbar spine w/o dye	2,975	2,039	68.5%	1,472	49.5%	\$ 254.28	\$ 231.25	-10.0%

**Notes**

MRI Agents included in the analysis: A9575, A9576, A9577, A9578, A9579, A9581, A9583, A9585

CT Agents included in the analysis: Q9951, Q9953, Q9956, Q9957, Q9958, Q9961, Q9962, Q9963, Q9964, Q9965, Q9966, Q9967

Other allocation methods include dollar allocation and direct allocation.

Table 2 of the CY 2021 HOPPS proposed rule shows the CCRs that would be in use under the HOPPS if CMS uses all CCRs for the CT and MRI cost centers irrespective of the cost allocation method that the hospital is using. CT Scans have a CCR of 0.0347 and MRI is 0.0764.<sup>3</sup> A CCR of 0.0347 suggests that hospitals are charging 27 times their costs for a CT exam. It is unreasonable to assume that this is correct. Further, the ACR notes that this problem has become worse, not better since 2009. Although the number of valid CT and MRI CCRs has increased over time, they still would have a negative effect on the payment rates of almost all of the imaging APCs if all data regardless of cost allocation were used.

<sup>3</sup> Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals, August 9, 2019, page 39408.

**Table 2.** CCR Statistical Values Based on Use of Different Cost Allocation Methods

Cost Allocation Method	CT		MR	
	Median CCR	Mean CCR	Median CCR	Mean CCR
All Providers	0.0347	0.0491	0.0764	0.1016
Square Feet Only	0.0286	0.0444	0.0665	0.0928
Direct Assign	0.0472	0.0564	0.0935	0.1183
Dollar Value	0.0414	0.0553	0.0858	0.1128
Direct Assign and Dollar Value	0.0415	0.0555	0.0866	0.1131

Furthermore, consistent with these findings, hospitals are unable to properly allocate indirect costs to an ancillary cost center comprised of capital equipment. The RTI study plainly stated this in the report:

“Charges and direct departmental costs are easy to recognize in the accounting records, but providers also need to capture indirect costs adequately by identifying separate allocation statistics. These particular services are very capital-intensive, and accurate cost ratios will depend on providers’ being able to assign actual equipment depreciation and lease costs directly to the cost centers, rather than the traditional method of allocating average capital costs based on square footage.<sup>4</sup>”

Excerpts from the RTI Report suggest the data has been problematic from the start:

“We were able to compute separately defined cost ratios for CT scanning in 25 percent of providers, and for MRI in 20 percent of providers, but in several of these the cost-to-charge ratios were so extremely low that it is likely that providers did not accumulate all of the costs, or possibly failed to identify allocation statistics to accumulate all of the indirect costs.<sup>5</sup>”

“Many facilities had very low cost ratios on these nonstandard lines, including many below 0.05. This raises questions about the relative accuracy of their cost finding.<sup>6</sup>”

The analysis conducted by the ACR and our consultants, demonstrated that 51% of providers who have claims for CPT code 70450 had a CCR of less than 0.05. These claims made up 61% of rate setting claims. The table below shows providers with CCRs less than 0.05 for 10 radiology CPT codes.

<sup>4</sup> Whitehead, N., Kautter, J., Mosquin, P., Lynch, J., Squiers, L., Newman, L., . . . Coomer, N. (2008). Evaluation of the Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration (Rep.). Waltham, MA: RTI International. Pg. 65

<sup>5</sup> Whitehead, N., Kautter, J., Mosquin, P., Lynch, J., Squiers, L., Newman, L., . . . Coomer, N. (2008). Evaluation of the Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration (Rep.). Waltham, MA: RTI International. Pg. 52

<sup>6</sup> Whitehead, N., Kautter, J., Mosquin, P., Lynch, J., Squiers, L., Newman, L., . . . Coomer, N. (2008). Evaluation of the Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration (Rep.). Waltham, MA: RTI International. Pg. 65

HCCPS	Number of Providers with CCR <0.05	Total Providers	% of Providers	Number of Rate Setting Claims by Providers with CCR <0.05	Total Number of Rate Setting Claims	% of Rate Setting Claims
70450	1,589	3,099	51%	1,242,817	2,034,000	61%
74177	1,571	3,036	52%	214,189	379,876	56%
74176	1,580	3,065	52%	155,003	265,828	58%
71260	1,555	2,991	52%	133,304	244,597	54%
71250	1,582	3,085	51%	459,552	805,487	57%
72148	567	2,901	20%	79,962	425,628	19%
70553	557	2,841	20%	53,184	300,661	18%
70551	567	2,938	19%	50,212	252,687	20%
73721	558	2,839	20%	36,020	192,025	19%
74183	527	2,595	20%	19,737	119,119	17%

The requirement that hospitals create standard cost centers for CT and MRI is complex and hospitals are unable to respond. The CCRs for selected CT and MRI procedures show a significant number of CCRs that are close to zero. These near zero CCRs indicate that even when hospitals create standard cost centers, they are likely unable to accurately re-allocate many costs that are already allocated across hospital departments to new CT and MRI departmental cost centers. For these hospitals, the CCRs probably reflect allocations of staffing and dedicated departmental expenses, while the costs of equipment, some costs associated with space (e.g., lead in walls), other administrative costs have been spread across all hospital departments and have not been moved.

The presence of these near zero CCRs will contribute to underestimated costs used in rate setting, pulling rates for CT and MRI procedures down below their actual cost and further eroding payment accuracy. No other high cost technologies are treated in this manner. Hospitals have standard accounting practices for high cost moveable equipment and it is inconsistent and burdensome to expect hospitals to account CT and MRI in a different manner than they deal with other types of equipment. As CMS moves away from granular procedure specific payment mechanisms across payment systems, it is inconsistent to focus on CT and MRI, treating them differently from all other technologies.





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Square foot providers account for approximately 51% of the claims used in rate setting for the five CT codes and 48% of the claims used in rate setting for the five MR codes analyzed. The table below shows that for most of these codes, the average volume weighted cost is lower among square foot providers.

HCPCS	2020P Short Descriptor	Square Feet Providers	Direct/Dollar /Other Providers	Percent Difference in Weighted Average Cost
		Weighted Average Cost	Weighted Average Cost	
70450	Ct head/brain w/o dye	\$ 102	\$ 101	1%
74177	Ct abd & pelv w/contrast	\$ 230	\$ 235	-2%
74176	Ct abd & pelvis w/o contrast	\$ 191	\$ 179	7%
71260	Ct thorax w/dye	\$ 136	\$ 151	-10%
71250	Ct thorax w/o dye	\$ 103	\$ 116	-11%
72148	Mri lumbar spine w/o dye	\$ 258	\$ 277	-7%
70553	Mri brain stem w/o & w/dye	\$ 366	\$ 418	-13%
70551	Mri brain stem w/o dye	\$ 256	\$ 271	-6%
73721	Mri jnt of lwr extre w/o dye	\$ 253	\$ 281	-10%
74183	Mri abdomen w/o & w/dye	\$ 372	\$ 433	-14%

However, it is important to note that it is not just those sites that report data under the square foot method that have data problems. Among providers using the direct or dollar cost allocation methods, over 60% of CT providers and 45% of MR providers had cost estimates that were below 85% of the national average cost.

Therefore, using the CT and MR cost centers in general is fraught with problems.

*Do Not Continue with the Planned Policy*

The ACR is concerned that the adverse impact of the implementation of flawed CT and MRI cost centers will extend beyond the scope of HOPPS. The use of separate CT and MRI CCRs will create unintended consequences on the technical component payment of CT and MRI codes in the Physician Fee Schedule (PFS). If this policy is finalized and fully implemented, the resulting reductions in hospital payments would also affect the office practice setting. This is because the HOPPS technical payments would fall below the payment rates in the PFS causing further cuts as mandated by the Deficit Reduction Act of 2005 (DRA). The DRA mandates that the PFS technical payments be paid at the PFS rate or HOPPS rate, whichever is the lower. Based on analysis of CMS data, codes affected by the DRA would experience payment reductions up to -52%. We have attached documentation entitled “ACR Comment Letter Appendix” that demonstrates the



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deterioration of MPFS TC payments by the DRA. By implementing policy, other payment systems will be negatively affected by the incorrect data being produced by this policy.

The ACR believes that these linked policies heighten the importance of ensuring that any changes made to the HOPPS methodology are fully justified. If payments are insufficient in the outpatient department and payments are lowered under the PFS to the HOPPS rate, access to advance imaging services will become a critical concern in all settings. ***The ACR believes that for the CY 2021 HOPPS final rule, that CMS set weights based on a single diagnostic radiology CCR—the same policy that CMS applied before it created separate CT and MRI standard cost centers in 2011.***

### **Proposed APC Placement of New and Revised CY 2021 Category I and III CPT Codes**

#### *Proposal*

CMS included proposed APC placement of new and revised CY 2021 Category I and III CPT Codes in Addendum B with a “NI” modifier indicator meaning CMS will accept comments in the proposed rule on the interim APC assignment for the new code.

#### *ACR Perspective and Comments*

***The ACR is pleased CMS agreed with the ACR’s recommendation for the APC placement of the new Category I CPT code 324X0 (Core ndl bx lng/med perq) into APC 5072.***

***The ACR does not agree with CMS’s decision to place new Category I CPT code 712X0 (Ct thorax lung cancer scr c-) into APC 5521.*** In a comment letter to CMS from February 26<sup>th</sup>, 2020, the ACR recommended 712X0 be placed in APC 5523. We are disheartened that CMS has placed 712X0 in APC 5521. In January 2019, the Relativity Assessment Workgroup referred G0297 to CPT to establish a permanent CPT code. The new category I CPT code for LDCT (712X0) screening is a reflection of the importance of screening in the prevention and treatment of lung cancer. Medicare beneficiaries between the ages of 55-77, and are long-term smokers or a former smoker (who quit within the last 15 years), are eligible for lung cancer screening with a Low Dose Computed Tomography (LDCT) examination. The ACR has been committed to improving access to LDCT lung cancer screening to Medicare beneficiaries.

Based on clinical similarity and resource use, CPT code 712X0 should be placed in a higher APC than CPT code 71250 (Ct thorax dx c-0), the more appropriate predecessor code for 712X0. In the CY 2021 HOPPS proposed rule, CPT code 71250 has a geometric mean of \$91.90. The new CPT code 712X0 should be placed in a higher APC than 71250 due to the increased reporting and staff requirements for conducting LDCT screening. Included in LDCT screening there are registry reporting requirements, necessary nurse navigators, and additional certifications required for the service that add costs to providing the service. Previously, CPT code G0297 was inappropriately placed in APC 5521 (Level 1 Imaging without Contrast). ***The ACR believes placing 712X0 in APC 5523 (Level 3 Imaging without Contrast) would more appropriate based on clinical similarity and resource use. Appropriate APC placement of 712X0 will ensure that patients have access to this life-saving screening service.***





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### *Proposal*

CMS proposes to place CPT code 7615X (Med physic dos eval rad exps ) in APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) with a proposed payment rate of \$129.86.

### *ACR Perspective and Comments*

APC 5611 currently has nine, clinically similar, radiation oncology therapeutic radiation treatment codes. Newly created CPT Code 7615X is not a radiation oncology code, rather a service that will be performed in interventional radiology or interventional cardiology. The ACR requests that CPT Code 7615X be placed in APC 5724 Level 4 Diagnostic Tests and Related Services. APC 5724 currently has 17 services, with a range of clinical variability (urology, neurology, internal medicine, radiology, dermatology, allergy, etc). The resource consumption in APC 5724 more closely aligns with the resources used to perform CPT code 7615X. ***The ACR believes the most appropriate placement of 7615X would be in APC 5724 (Level 4 Diagnostic Tests and Related Services) with a payment rate of \$936.70.***

### *DRA Cap*

The ACR is concerned that CMS included CPT Code 7615X in the CY2021 PFS proposed-rule-outpatient-cap-list (codes subject to DRA cap). The Deficit Reduction Act (DRA) caps Medicare payment amounts for certain imaging service at the amount paid to hospitals under the HOPPS. Unless changed, this will cap PFS reimbursement at a rate far lower than what was recommended by CMS in the PFS proposed rule. ***We urge CMS to remove CPT Code 7615X from the DRA cap list.***

## **Proposed APC Placement of Cardiac CT CPT Codes**

### *Proposal*

CMS proposes to place CPT codes cardiac CT codes 75572, 75573, and 75574 into APC 5571 (Level 1 Imaging with Contrast) with a payment rate of \$181.41.

### *ACR Perspective and Comments*

The ACR does not agree with CMS's placement of cardiac CT codes 75572, 75573, and 75574 into APC 5571. ***Cardiac CT should be reassigned to APC 5572 or 5573, to bring into better alignment with clinical homogeneity and cost/resource utilization.*** The three cardiac CT codes (75572, 75573, 75574) should never have been placed in APC 5571, as cardiac CT exams require substantially more time and resources than any of the tests assigned to APC 5571. Cardiac CT uses a CT scanner and is far more similar to services in APCs 5573 than to services in APC 5571. Cardiac CT exams require more time, require highly trained technologists who reformat non-orthogonal projections, involve higher risk patients, require administration of vasoactive medications, and require close monitoring of patients during and after the procedure. The need for all these resources is vastly different from other contrast-enhanced imaging studies in 5571 which are simpler and may only take a fraction of the time. Moreover, this test has been shown to be highly cost-effective in evaluating acute chest pain in the emergency setting by reducing hospital admissions and precluding the need for costlier interventional procedures (PMID: 22209422). APC misallocation will only serve to stunt further adoption. ***The ACR asks that CMS uses its authority to move 75572 & 75573 contrast-enhanced cardiac CT codes to APC 5572 and move 75574 to APC 5573.***



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## **Proposed APC Placement for Cardiac Magnetic Resonance Services**

### *Proposal*

CMS proposes to place cardiac MR CPT code 75561 in APC 5572 and CPT code 75563 in APC 5573.

### *ACR Perspective and Comments*

The ACR remains very concerned about the lack of payment stability for cardiovascular magnetic resonance services, particularly CPT 75561 and 75563. CPT 75561 and CPT 75563 have sustained significant payment disruptions. These codes represent the most commonly performed cardiovascular magnetic resonance services. The ACR remains concerned about the lack of payment stability for CPT 75561 (Cardiac mri for morph w/dye). Under the proposed APC structure for 2021, CPT code 75561 remains in APC 5572, grouped with services that are not clinically similar or similar in resource use. Given the continued reduction in payment, it is likely that hospitals will choose not to offer this service to patients. ***The ACR asks that CMS move CPT 75561 to APC 5573.*** Until 2017, CPT 75563 was placed in an APC with comparable nuclear medicine services. ***The ACR asks that CPT code 75563 (Card mri w/stress img & dye) be removed from the proposed placement in APC 5573 and be moved back to APC 5593.***

## **Proposed APC Placement of Single-Photon Emission Computed Tomography (SPECT) CPT Code**

### *Proposal*

CMS proposes to place CPT code 78803 (Rp locl zj tum spect 1 area) into APC 5592 (Level 2 Nuclear Medicine and Related Services).

### *ACR Perspective and Comments*

**The ACR urges CMS not to place SPECT CPT code 78803 in APC group 5592; instead, we recommend that CMS place the revised code 78803 in APC group 5593 (Level 3 Nuclear Medicine and Related Services).** As you know, SPECT CPT code 78803 was revised by the CPT Editorial Panel for the current calendar year, along with the deletion of multiple SPECT codes, including 78320 (SPECT bone), 78607 (SPECT brain), 78647 (SPECT CSF), 78710 (SPECT kidney), 78807 (SPECT infection), 78205 (SPECT liver), and 78206 (SPECT liver and flow). As a result, CPT code 78803 is now more generic and will apply to a variety of radiopharmaceuticals and organs going forward. Placement of CPT code 78803 in APC group 5592 would not account for the specialized nature of certain SPECT codes that were deleted during this process; for example, CPT code 78607 (SPECT brain), would not be appropriately reimbursed under APC group 5592, as proposed. During last year's rulemaking, CMS also proposed cross walking CPT code 78803 to APC group 5592, and after its careful consideration of stakeholder comments, CMS made the proper adjustment in the CY 2020 HOPPS Final Rule to crosswalk CPT code 78803 in APC group 5593.



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**Conclusion**

The ACR appreciates the opportunity to comment on the HOPPS proposed rule. We hope you find these comments provide valuable input for your consideration. If you have any questions, please don't hesitate to contact Christina Berry at [cberry@acr.org](mailto:cberry@acr.org).

Respectfully Submitted,

William T. Thorwarth, Jr., MD, FACR  
Chief Executive Officer

- cc: Marjorie Baldo, CMS
- Scott Talaga, CMS
- Terri Postma, MD, CMS
- Josh McFeeters, CMS
- Erick Chuang, CMS
- Lela Strong-Holloway, CMS
- Greg Nicola, MD, ACR
- Norman Thomson, MD, ACR
- Kurt Schoppe, MD, ACR
- Christina Berry, ACR
- Angela Kim, ACR
- Kathryn Keysor, ACR