September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma:

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) on the calendar year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Proposed Rule.

In this comment letter, we address the following important issues:

- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services (ADIS)
- Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services
- Preservice Clinical Labor for 0-Day and 10-Day Global Services
- Updates to Prices for Existing Direct Practice Expense (PE) Inputs
- Practice Expense Refinements
- Proposed Valuation of Specific Codes
- Determination of Professional Liability Insurance Relative Value Units (PLI RVUs)
- Medicare Telehealth Services
- Proposed Payment Rates Under the MPFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital

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Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The proposed rule outlines CMS's continued plan for implementing Section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA), establishing a program to mandate the use of AUC for ADIS. The ACR greatly appreciates CMS's willingness to engage stakeholders in this process and for the consideration of our input during this rulemaking cycle. We look forward to continued collaboration as the program moves closer to implementation.

Timeframe and Claims Processing Instructions

Proposals

CMS is proposing that ordering professionals must consult specified applicable AUC through qualified clinical decision support mechanisms (CDSMs) for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. CMS asserts that this timeframe allows time for ordering practitioners who are not already aligned with a qualified CDSM to research and evaluate the CDSMs so they may make an informed decision. This also allows time for education and outreach efforts.

Unless a statutory exception applies, an AUC consultation is required for every order of an applicable imaging service furnished in an applicable setting under an applicable payment system. Payment for the imaging service may only be made if the claim for the service includes information on which a qualified CDSM was consulted by the ordering professional, whether or not the service ordered would adhere to specified applicable AUC and the National Provider Identifier (NPI) of the ordering professional.

To implement the reporting requirement, CMS proposes to establish a series of Healthcare Common Procedure Coding System (HCPCS) level 3 codes. These G-codes would describe the specific CDSM that was used by the ordering professional. Ultimately, there would be one G-code for every qualified CDSM with the code description including the name of the CDSM. CMS would expect that one AUC consultation G-code would be reported for every advanced diagnostic imaging service on the claim. Each G-code would be expected, on the same claim line, to contain at least one new HCPCS modifier. CMS proposes to develop a series of modifiers to provide necessary information.

Due to the complex nature of the program, CMS is proposing an "educational and operations testing period" of one year, beginning January 1, 2019. During this period, ordering professionals would consult AUC. Furnishing professionals would report AUC consultation information on the claim, but CMS would continue to pay claims whether or not they correctly include the required information.

ACR Perspective and Comments

Implementation Timeline

The ACR applauds CMS's willingness to work with providers to move the AUC program forward as expeditiously as possible. Although we remain concerned with the delay beyond the January 1, 2017 effective date required by PAMA, we agree with CMS that implementation of this important program should occur in a thoughtful, stepwise manner with robust stakeholder engagement. Accordingly, we support the January 1, 2019 implementation date and the one year educational and testing period.

Since PAMA became law in 2014 and based on CMS's proposed 2019 start date, CMS and ordering professionals have been granted, at a minimum, five years of lead time prior to the full implementation of the PAMA imaging AUC policy. In the meantime, AUC-CDS has now been successfully adopted through electronic health record (EHR) integration in over 250 health systems and 2,000 acute care facilities in all 50 states as well as being available via a free web portal. Millions of CDS transactions occur each month in these systems using AUCs from multiple physician specialty societies and other provider-led entities, such as the National Comprehensive Cancer Network (NCCN).

A relatively small number of national physician organizations suggest delaying the implementation of PAMA's imaging AUC policy simply because it coincides with the start of major components of the broader CMS Quality Payment Program (QPP). These concerns are unfounded and mischaracterize Congressional intent to move forward on a diagnostic imaging utilization program which occurred months before a consensus was achieved on what ultimately became the Medicare Access and CHIP Reauthorization Act (MACRA). Furthermore, these critiques surrounding the interaction of the PAMA AUC policy and MACRA have largely been rendered moot by provisions included in the CY 2018 QPP Proposed Rule. More specifically, this most recent regulation to implement MACRA includes provisions to add a new high weighted improvement activity that clinicians eligible to participate in the Merit-based Incentive Payment System (MIPS) could choose if they attest they are using AUC through a qualified CDSM for all advanced diagnostic imaging services ordered. In addition, the MPFS proposed rule indicates that CMS is exploring how the AUC program can serve to support a measure under the MIPS quality performance category. We applaud CMS's efforts to find ways to encourage more rapid adoption of AUC consultation for advanced diagnostic imaging and to reward these clinicians through the QPP. **The ACR strongly believes that implementation can occur on this date and urges CMS not to delay implementation beyond January 1, 2019.**

With regard to the education and testing period, the proposed rule indicates that the ordering professionals would be required to consult AUC and the furnishing professional required to report the appropriate information on the claim without penalty for incorrect reporting. **The ACR requests clarification on whether or not there would be a penalty if AUC is not consulted and/or reported on the claim at all.**

Claims Processing

While the proposed method of reporting G-codes and modifiers on the furnishing professional's claim is potentially a feasible option for implementing the AUC program, the ACR has concerns with shortcomings in this system. In the CY 2017 MPFS final rule, CMS finalized requirements for qualified CDSMs. These requirements include, "Certification or documentation must be generated each time an ordering professional consults a qualified CDSM and include a unique consultation identifier generated by the CDSM."[1] In 42 C.F.R. section 414.94(g)(1)(vi), CMS's regulations require all qualified CDSMs to "Generate and provide a certification or documentation at the time of order that documents which qualified CDSM was consulted; the name and national provider identifier (NPI) of the ordering professional that consulted the CDSM; whether the service ordered would adhere to specified applicable AUC; whether the service ordered would not adhere to the specified applicable AUC; or whether the specified applicable AUC consulted was not applicable to the service ordered." In addition, the regulation specifies that the "[c]ertification or documentation must: (A) Be generated each time an ordering professional consults a qualified CDSM" and "(B) Include a unique consultation identifier generated by the CDSM."[2]

We believe that the most straightforward and least administratively burdensome way to implement the AUC program is simply to require reporting of the unique consultation identifier (UCI) on the claim. Having created the concept of a reserved claims line for consultation reporting, CMS has plenty of space on the CMS-1500 and CMS-1450 forms to require furnishing professionals to report UCIs.

Not only will the UCI link to the information that section 1834(q)(4)(B) of the Social Security Act requires, but it will provide information on the outcome of the consult prior to the determination that a study was or was not adherent. In particular, analyses can be performed for circumstances when the ordering professional, as a result of the consultation, decided not to order any advanced diagnostic imaging test -- which the ACR understands is the most common "change" made in physician orders as a result of consultation and, in fact, contributes the highest value of that consultation. Since the goal is to reduce or eliminate inappropriate imaging, this information is essential in evaluating the success of the AUC effort. Additionally, this information may also be used in the implementation of the future outlier policy. Thus, from both a policy evaluation and a payment-integrity standpoint, including the UCI on the claim would give CMS valuable information, including for those consultations that do not result in a claim.

One of our fundamental concerns with CMS's current G-code proposal is the lack of instructions for communication of the pertinent information from the ordering professional to the furnishing professional. The furnishing professional is expected to report the appropriate G-codes and modifiers with the required information, but as proposed, there is no guidance on how the furnishing professional will receive this information. Requiring the UCI on the order, and

1 81 Fed. Reg. 80170, 80418 (Nov. 15, 2016).

2 42 C.F.R. § 414.94(g)(1)(vi).

subsequently on the claim, could provide all of the required information in the most efficient manner with much less administrative burden.

Additionally, under CMS's proposal, information about the ordered study's adherence to guidelines is treated as a binary "adherent" versus "non-adherent" judgment reported via high-level modifiers. If implemented as proposed, each CDSM will apparently have to make a determination of how it will draw this line. In established AUC consultation programs such as ACR Select, adherence scores are not binary, but rather reflect a continuum ranging from "almost certainly adherent" to "almost never adherent" -- with substantial room for evidentiary nuances in between these extremes. One of the purposes of UCI reporting in the ACR Select scheme is that it provides a direct trail to the full set of information generated during the AUC consultation, including the granular score of the test presented, which CMS could deem to fully satisfy the statutory requirement to report adherence. Absent further guidance from CMS, CDSMs may differ on where they draw the line between adherence and non-adherence. If they do differ, the resulting data would be useless for purposes of evaluating ordering patterns across ordering professionals, since physicians and providers would have the capacity to shop for the qualified CDSM that is most lenient given the profile of tests typically ordered.

The ACR believes that CMS should require that a UCI be reported on orders submitted to furnishing professionals so they may report it on their claims. Every CDSM should be required to provide access to CMS or its Medicare Administrative Contractors to the complete set of transaction records created in its capacity as a qualified CDSM.

Performance of the Consultation

The ACR is concerned about some potential for misinterpretation in the referring provider and radiology community as to whether the furnishing professional may consult AUC on behalf of the ordering professional. The statute is clear that the ordering professional is required to consult the AUC, which we believe requires the ordering professional to see and meaningfully interact with the CDS program. Congress's intent is to educate ordering professionals in the optimal use of ADIS. This education cannot take place if they are not consulting the AUC themselves. Moreover, it is the ordering professional who has a complete understanding of the patient's medical history and past imaging evaluation including radiation exposure and is in the best position to weigh this information together with the appropriateness criteria. **We urge CMS to provide specific guidance on this issue in the final rule.**

Alignment with Other Medicare Quality Programs

Proposals

CMS notes that the CY 2018 QPP proposed rule includes a proposal to give MIPS credit to ordering professionals for consulting AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning January 1, 2018. The Agency believes this will incentivize early use of qualified CDSMs to consult AUC by motivated eligible

clinicians who are looking to improve patient care and better prepare themselves for the AUC program.

ACR Perspective and Comments

The ACR appreciates the inclusion of this improvement activity as we strongly support the AUC provisions of PAMA and encourage their implementation. We also strongly encourage CMS to reword this improvement activity so that radiologists can obtain credit for supporting their referring clinicians in the implementation of AUC consultation through qualified CDSMs such as the following:

- A MIPS eligible clinician would attest that they are consulting specified, or providing radiological consultative services in association with, appropriate use criteria for advanced diagnostic imaging.

This additional language and qualification is consistent with what CMS allows for Radiology Support Communication and Alignment Network (RSCAN) participants under the transforming clinical practice initiative (TCPI).

Provider Led Entity (PLE) Endorsement of AUC

CMS allows qualified PLEs to develop, modify or *endorse* specified applicable AUC. The ACR is concerned about the lack of transparency with regard to AUC endorsement and the interpretation of this concept. As a qualified PLE, the ACR has formed relationships with some organizations, but not with others. CMS's regulations specifically state, "Qualified PLEs may endorse the AUC set or individual criteria of other qualified PLEs, *under agreement by the respective parties,* in order to enhance an AUC set."[3] Yet certain organizations have "endorsed" ACR's AUC without advising ACR that they have done so, let alone obtaining ACR's agreement. References to another qualified PLE's AUC, without that qualified PLE's concurrence, do not comply with the regulation and fail to adhere to the informed process that CMS established. **Consequently, we request that CMS reiterate in this year's final rule that each qualified PLE that endorses another qualified PLE's AUC must document that it has obtained that organization's agreement.**

Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services

Proposal

The Consolidated Appropriations Act of 2016 provides for a 7 percent reduction in payments for the technical component (TC) of imaging services made under the MPFS that are X-rays taken using computed radiography (CR) technology furnished during CYs 2018-2022 and a 10 percent

[3] 42 C.F.R. § 414.94(d) (emphasis added).

reduction for such services furnished during CY 2023 and beyond. Computed radiography technology is defined as cassette-based imaging that uses an imaging plate to create the image involved.

CMS is proposing the development of a new modifier (to be specified in the final rule) to be used on claims for computed radiography services beginning on January 1, 2018. The modifier would be required on claims for the technical component of the X-ray service, including when the service is billed globally because the MPFS payment adjustment is made to the technical component regardless of whether it is billed globally or billed separately using the –TC modifier. The modifier must be used to report the specific services that are subject to the payment reduction. Its accurate use is subject to audit.

ACR Perspective and Comments

The CMS proposal is consistent for the implementation of the payment reductions for imaging performed using film in 2017. **The ACR supports the proposal to develop a new modifier to be used on claims for computed radiography services, but asks that CMS release the modifier as soon as possible to give physicians' offices and hospitals adequate time to implement the modifier into their billing practices. The ACR also asks that CMS acknowledge that many radiology practices must also work out the difficult logistics of how to identify portable X-ray studies that are performed with CR versus digital radiography (DR) in order to appropriately append the modifier and receive the reduced payment.**

Preservice Clinical Labor for 0-Day and 10-Day Global Services

Proposal

Several years ago, the RUC's PE Subcommittee reviewed the preservice clinical labor times for Current Procedural Terminology (CPT®)[4] codes with 0-day and 10-day global period and concluded that these codes are assumed to have no preservice clinical staff time unless the specialty can provide evidence that the preservice time is appropriate. CMS notes that for CY 2018, 41 of the 53 reviewed codes with 0-day or 10-day global periods include preservice clinical labor of some kind. Because 77 percent of the reviewed codes for the current calendar year deviate from the "standard," CMS is seeking comment on the value and appropriate application of the standard in their review of RUC recommendations in future rulemaking. CMS would specifically like comment on whether the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking.

CMS indicates that the assumption behind the standard is that for minor procedures there is "no clinical staff time typically spent preparing for the specific procedure prior to the patient's arrival." The ACR supports the RUC's position that it is accurate to assume that no clinical staff time is necessary for minor procedures. However, as more procedures are able to be performed

[4] CPT is a registered trademark of the American Medical Association (AMA).

without extensive follow-up it is no longer true that all 0-day and 10-day globals can be classified as minor procedures. In other words, there is no pre-service time typical for minor procedures, but the RUC has concluded that it is no longer appropriate to determine whether a procedure is minor or major based on it being a 0 or 10-day global.

ACR Perspective and Comments

The ACR appreciates CMS's consideration of this issue. We believe that it is most appropriate to evaluate preservice clinical labor times on a code-by-code basis rather than using a standard of no preservice time. **The ACR strongly opposes eliminating clinical staff preservice time from all 0- and 10-day global procedures in future rulemaking.**

The ACR urges CMS not to make this unilateral change as the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) PE Subcommittee works with the specialty societies to develop a strategy to better determine which services truly are minor and what criteria the RUC should use moving forward to determine which codes require no pre-service clinical staff time.

Updates to Prices for Existing Direct PE Inputs

CMS is proposing to change the name of the ED050 equipment from "PACS Workstation Proxy" to the "Technologist PACS workstation" to avoid confusion between the technical PACS workstation and the professional PACS workstation.

The ACR supports this equipment name change.

Practice Expense Refinements

We have attached a spreadsheet, which includes the ACR comments on CMS's refinement of RUC-recommended practice expense direct inputs.

Proposed Valuation of Specific Codes

CMS has indicated a shift in its approach to reviewing RUC recommendations, and it is relying more heavily on RUC-recommended values for CY2018. However, CMS also includes potential alternative methods of valuation for consideration and are seeking comment on both the RUC-recommended values and the alternative values proposed.

The ACR is appreciative of CMS's support of the RUC process and the RUC-recommended values.

Cryoablation of Pulmonary Tumor (CPT codes 32998 and 32X99)

The ACR appreciates and agrees with the agency's proposal to accept the RUC-recommended values of 9.03 RVUs for both CPT codes 32998 and 32X99.

Both of these codes describe using imaging guidance to ablate a pulmonary tumor, either using heat (radiofrequency, 32998) or cold (cryoablation, 32X99). Bundling imaging guidance into these services is appropriate because it is fundamental to performing these procedures. In other words, neither procedure could be performed without imaging guidance. Any claims which lack an associated imaging guidance code are due to improper coding, either leaving off 77013 or using a different imaging guidance code inappropriately (e.g. 77012). Therefore, while we understand CMS's concern about bundling in imaging guidance given the analysis of the 2014 claims data, we consider the new codes a solution to this question since, by definition, both procedures require imaging guidance to be performed.

Endovascular Repair Procedures (EVAR) (CPT codes 34X01, 34X02, 34X03, 34X04, 34X05, 34X06, 34X07, 34X08, 34X09, 34X10, 34X11, 34X12, 34X13, 34812, 34X15, 34820, 34833, 34834, 34X19, and 34X20)

The ACR appreciates and agrees with the proposal to accept the RUC-recommended values and practice expense inputs for the extensive EVAR code family.

However, the ACR disagrees with selectively accepting the survey 25th percentile values or using alternative crosswalks to avoid perceived rank order anomalies for 34X02, 34X04, 34X06, and 34X08. All four of these codes describe work in an emergent setting in a traumatically damaged vessel (e.g. ruptured aneurysm, pseudo-aneurysm, dissection, penetrating ulcer, or trauma). The work values for these codes are all appropriately higher than the corresponding non-traumatic codes (34X01, 34X03, 34X05, and 34X07, which describe work in an intact vessel) given the different patient populations and anatomic considerations when performing these services. Using either the 25th percentile survey values or the proposed crosswalks would inappropriately undervalue these procedures performed in ruptured vessels and create a rank order anomaly. Moreover, the proposed crosswalks are unrelated to the 34X02 and 34X04 services, and were seemingly selected only for the proximity to the 25th percentile survey values as opposed to their clinical work similarity.

We also disagree with potentially changing the eight ZZZ codes in the EVAR family to 000 day global codes. We acknowledge the concerns of the agency that these codes would not be subject to the multiple procedure payment reduction. However, the purpose of these add-on codes is to capture separate physician work that can only be done in addition to the base procedure. By definition, the physician work and practice expense resources of the ZZZ codes do not overlap with the base codes (e.g. no allowed pre- or post-service time even when clinically appropriate). Therefore, there are no existing efficiencies to capture with the multiple procedure payment reduction (MPPR). For the purposes of correct coding, the ZZZ global period is the clinically

appropriate and the most accurate way to describe these services, and the RUC-recommended values accurately reflect this.

Selective Catheter Placement (CPT codes 36215, 36216, 36217, and 36218)

CPT code 36215 was identified as potentially misvalued on a screen of Harvard-valued codes with utilization over 30,000, as well as by the CMS High Expenditure by Specialty Screen. This family was expanded to include CPT codes 36216, 36217, and 36218. The ACR appreciates and agrees with the proposal to accept the RUC-recommended values for 36215, 36216, 36217, and 36218.

The ACR agrees with the RUC's recommendation to use the survey 75 percent intraservice work time for CPT code 36217, which is actually appropriate from a clinical standpoint as the time increment between codes 36216 and 36217 was not long enough to account for the additional work of 36217. If the agency reduces the intraservice time for 36217 by 10 minutes (to the survey median time), this does not "preserve the incremental, linear consistency between the work RVU and intraservice time within the family" as suggested. Rather, it is clinically incongruous given the work and time it would take for a procedure to progress to 36217 as opposed to 36216. We recognize the appeal of having a straight linear stepwise increase, but this does not track with the clinical work. Therefore, we support the adjusted intra-service time for 36217 as was discussed extensively at the RUC.

Insertion of Catheter (CPT codes 36555, 36556, 36620, and 93503)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.93 RVUs for CPT code 36555, 1.75 RVUs for CPT code 36556, 1.00 RVU for 36220, and 2.00 RVUs for CPT code 93503.

Insertion of PICC Catheter (CPT code 36569)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended value at 1.70 RVUs for CPT code 36569.

CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.28 RVUs for CPT code 70490, 1.38 RVUs for CPT code 70491, and 1.62 RVUs for CPT code 70492.

We disagree with the potential crosswalk of CPT code 70490 to 72125 at 1.07 RVUs. While these codes have the same intra-service time, the clinical work is different, due to the patient population and intensity of the services provided. CPT code 72125 is a CT of the cervical spine, which excludes many of the soft tissue structures in the neck to concentrate on the osseous structures in the cervical spine, usually in the setting of trauma. CPT code 70490 is a CT

covering both the soft tissues in the neck and the cervical spine, which is more often performed in patients with malignancy or infection involving the complicated soft tissue planes in the neck that may also involve the spine. These differences in patient population and the anatomy included in the exam justify the higher work value for 70490 compared to 72125.

The ACR also disagrees with the methodology proposed to use an incremental difference between the suggested crosswalk and target code as CMS proposed for 70490 to similarly decrease the values of contrast enhanced codes, 70491 and 70492. There is not a standardized difference in work between the without and with contrast codes because each exam is different depending upon the modality, clinical circumstance, typical patient, and body part being examined. The value of the RBRVS is its ability to capture these intensity differences and appropriately account for them in each clinical context.

Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.20 RVUs for CPT code 70544, 1.20 RVUs for CPT code 70545, and 1.48 RVUs for CPT code 70546.

MRI and MR Angiography are complex imaging modalities and sometimes the physics is counterintuitive. The ACR recognizes this as a potential source of confusion, and we appreciate the opportunity to discuss the clinical labor times related to acquiring MR angiography images. Please note that the RUC-submitted PE times are accurate, and the perceived discrepancy is because of the unique physics related to acquiring MR Angiography images as opposed to the typical MRI. During an MR Angiogram with contrast, images are acquired of a "blood pool of contrast" as opposed to enhancement of soft tissues or masses in a typical MRI with contrast. Blood pool imaging can be performed more quickly than the typical MRI evaluating for enhancement because of the higher signal to noise ratio of contrast within the blood vessels (i.e. high relaxivity) compared to contrast diffused throughout the soft tissues.

The parameters used to acquire the images are different, taking advantage of the chemical properties of gadolinium when it is in high concentration (i.e. contained only within the blood vessels) versus low concentration (i.e. in the soft tissues). In the absence of intravenous gadolinium contrast, the acquisition of images takes a longer time to visualize the blood vessels because the signal received from the vessels is much lower compared to the adjacent soft tissues/structures. Once intravenous contrast is given, the scan time decreases because the contrast pools in the vessels, increasing their relative signal. As such, less time is required to acquire post contrast MRA images compared to the without contrast images because the signal from these vessels is much stronger than the adjacent soft tissues/structures.

Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.20 RVUs for CPT code 70547, 1.50 RVUs for CPT code 70548, and 1.80 RVUs for CPT code 70549.

As previously noted, MRI and MR Angiography are complex imaging modalities and sometimes the physics is counterintuitive. The ACR recognizes this as a potential source of confusion and appreciate the opportunity to discuss the clinical labor times related to acquiring MR angiography images. Please note that the RUC-submitted PE times are accurate, and the perceived discrepancy is because of the unique physics related to acquiring MR Angiography images as opposed to the typical MRI. During an MR Angiogram with contrast, images are acquired of a "blood pool of contrast" as opposed to enhancement of soft tissues or masses in a typical MRI with contrast. Blood pool imaging can be performed more quickly than the typical MRI evaluating for enhancement because of the higher signal to noise ratio of contrast within the blood vessels (i.e. high relaxivity) compared to contrast diffused throughout the soft tissues. The parameters used to acquire the images are different, taking advantage of the chemical properties of gadolinium when it is in high concentration (i.e. contained only within the blood vessels) versus low concentration (i.e. in the soft tissues). In the absence of intravenous gadolinium contrast, the acquisition of images takes more time to visualize the blood vessels because the signal received from the vessels is much lower compared to the adjacent soft tissues. Once intravenous contrast is given, the scan time decreases because the contrast pools in the vessels, increasing their relative signal. As such, less time is required to acquire post contrast MRA images compared to the without contrast images because the signal from these vessels is much stronger than the adjacent soft tissues/structures.

CT Chest (CPT Codes 71250, 71260, and 71270)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.16 RVUs for CPT code 71250, 1.24 RVUs for CPT code 71260, and 1.38 RVUs for CPT code 71270.

For CPT code 71250, the ACR is disappointed that CMS considered maintaining the current work RVU of 1.02 by pointing out that the time and intensity of the service has not changed. This is true. The physician time and intensity of interpreting a chest CT has not changed since it was last valued. That is why we support the RUC in recommending the prior work RVU from 2009 of 1.16. This work value is supported by both the old and new survey data. When this service was last valued in 2009, CMS used a flawed methodology for deriving the work RVU. CMS inexplicably used the single lowest response to the survey to set the work RVU at 1.02. We believe using a work RVU based on a single data point, the survey minimum RVU, is not only statistically invalid, but inappropriate. To then use this flawed reasoning as a building block to derive alternate values for 71250 and 71270 is similarly arbitrary and invalid.

The RUC recommendations are appropriate relative to other CT services which involve a similar amount of physician time. The RUC compared 71250 to Multi-Specialty Points of Comparison (MPC) code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times, whereas the survey is somewhat less intense. The RUC also compared 71250 to CPT code 78071 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)* (work RVU= 1.20, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times and involve similar amounts of physician work. The RUC compared 71260 to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and involve similar physician work. The RUC compared 71270 to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times, while the survey code involves somewhat more physician work.

MRI of Abdomen and Pelvis (CPT codes 72195, 72196, 72197, 74181, 74182, and 74183)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.46 RVUs for CPT code 72195, 1.73 RVUs for CPT code 72196, 2.20 RVUs for CPT code 72197, 1.46 RVUs for CPT code 74181, 1.73 RVUs for CPT code 74182, and 2.20 RVUs for CPT code 74183.

We also agree with CMS that the time for acquiring images should be adjusted, and that 30 minutes each for codes 74181 and 74182 is reasonable from a clinical standpoint as well as in comparison to other MRI codes.

MRI Lower Extremity (CPT codes 73718, 73719, 73720)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.35 RVUs for CPT code 73718, 1.62 RVUs for CPT code 73719, and 2.15 RVUs for CPT code 73720.

Abdominal X-Ray (CPT Codes 74022, 740X1, 740X2, and 740X3)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended work values for these codes, at 0.18 RVU for CPT code 740X1, 0.23 RVU for CPT code 740X2, 0.27 RVU for CPT code 740X3, and 0.32 for CPT code 74022.

Angiography of Extremities (CPT codes 75710 and 75716)

The ACR appreciates and agrees with the proposal by CMS to accept the RUC-recommended values at 1.75 RVUs for CPT code 75710 and 1.97 RVUs for CPT code 75716.

We disagree with decreasing the time associated with the clinical labor activity of "*Technologist QC's images in PACS, checking for all images, reformats, and dose page"* from 4 minutes to 3 minutes. The "standard" clinical labor times are a guideline and not absolute. For this particular activity, the technologist has to manage numerous imaging series performed during the angiography procedure, select the most appropriate images, properly label them, and format the finalized exam appropriately. This amount of work is similar to the work in code 75635 and the MRI Angiography codes (70544, 70545, 70546, 70547, 70548, and 70549), which should also have 4 minutes of time for this task. This additional time appropriately accounts for the larger number of images and more specialized quality control work related to angiography compared to other CT and MRI codes, which currently have 3 minutes of labor for this activity.

Ultrasound of Extremity (CPT codes 76881 and 76882)

The RUC identified CPT codes 76881 and 76882 for review of PE inputs based on a change in the predominant specialty performing these procedures in the office setting.

The ACR disagrees with the proposal from CMS to remove 1 minute from the clinical labor task *"Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue,"* in code 76881. While this code may not include any equipment time for the PACS workstation proxy or professional PACS workstation, this line item is a general description of the staff activity needed to create the billing forms related to the procedure. Even if there are no exam documents to be scanned into PACS or a RIS system used to store the information and manage billing, both of these activities must occur for a billing claim to be generated. Therefore, there should still be staff time allocated to this activity.

Determination of Professional Liability Insurance Relative Value Units (PLI RVUs)

Low Volume Service Codes

The ACR applauds the CMS proposal to override claims data for low volume services with an expected specialty for both the practice expense and professional liability insurance valuation process. This proposal is consistent with a long-standing RUC recommendation to use the expected specialty for services performed less than 100 times per year. Even a few claims made in error by one physician could result in substantial year-to-year payment swings to these codes. This has been particularly problematic when the low volume services in Medicare are actually high volume codes in the Medicaid or private pay population.

The ACR is concerned specifically about existing codes with no Medicare volume reported for any given year. According to the contractor report, CPT codes lacking utilization received a crosswalk created by CMS that assigns the same risk factor as codes with a similar specialty mix. In contrast, when a service is reported with no Medicare volume, it receives the average risk factor for all physician specialties. The crosswalks are clear when related to new CPT codes reviewed by the RUC, as the RUC provides, and CMS uses, specified crosswalks for each code selected to ensure the providing specialties are analogous. However, it is inappropriate for a service to have fluctuating PLI risk factors simply due to whether or not it is reported in Medicare claims data for a given year. **Therefore, the ACR recommends that the proposed list of expected specialty overrides be utilized for both low volume and no volume codes.**

Medicare Telehealth Services

Proposal

CMS is proposing to add HCPCS code G0296 *(Counseling visit to discuss need for lung cancer screening using low dose CT scan)* to the list of approved telehealth services. The Agency believes that this service is similar to office visits currently on the telehealth list and that all components of this service can be furnished via interactive telecommunications technology.

ACR Perspective and Comments

We believe that the ability of physicians to conduct this visit via telehealth will improve patient access to lung cancer screening. CT lung cancer screening is the first cost-effective diagnostic test proven to significantly reduce lung cancer deaths.

The ACR supports the addition of HCPCS code G0296 to the list of approved telehealth services.

Proposed Payment Rates under the PMFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments (PBDs) of a Hospital

Proposals

CMS proposes to revise the physician fee schedule (PFS) relativity adjustor for nonexcepted items and services furnished by nonexcepted off-campus PBDs to be 25 percent of the outpatient prospective payment system (OPPS) payment rate. For 2018, CMS is not using the 22 services upon which it determined the PFS relatively adjustor for 2017 but is instead using a weighted average of the difference between the facility and non-facility amount for procedure codes 99201 – 99215 and comparing it to G0463—the one service used to bill an evaluation and management (E/M) service under the OPPS. CMS does not provide the data upon which it made its determination of the PFS relativity adjustor although our analysis suggests that the weighted average is predominantly based on CPT codes 99213 and 99214. CMS also indicates that it does not have any more precise data upon which to make a determination of the PFS relatively

adjustor. Therefore, based on E/M services, which are the most common services in off-campus sites that bill using the –PO modifier, CMS proposes to reduce the payments to off-campus sites from 50 to 25 percent.

ACR Perspectives and Comments

We understand that CMS considers the CY2017 policy to pay off-campus sites at 50 percent of OPPS to be transitional, however, we believe that CMS's proposal to pay off-campus sites at 25 percent will not provide adequate payment for services provided at off-campus sites, especially for radiology. When determining the relativity adjustor CMS looks at the difference between the facility and the non-facility amount paid under the PFS for a given service and divides it by the OPPS payment for the same service. For surgical and E/M codes, there is one payment that represents the professional and practice expense portion of the service. There is no professional and technical relative value distinction as currently exists for radiology and other diagnostic services as represented by the professional component (-26) and technical component (–TC). For services with professional/technical component splits, there is no differentiation in the PFS payment by site of service and the TC portion of the service is only priced under the PFS in the non-facility setting. CMS compares the full non-facility payment to the OPPS payment.

The rationale for CMS's methodology is that if payments between the physician and outpatient department were to be exactly site neutral, CMS would only pay the higher non-facility MPFS payment when a service is done in an off-campus PBD just as it does when a PFS service is done in the office. Even under CMS's own rationale, the proposal to pay at 25 percent of the OPPS rate underpays most of the services listed on table 9. The column 5 percentage is higher than 25 percent for 17 of the 22 services listed indicating that CMS's proposal will pay hospitals for these services at *less* than a site neutral rate. If CMS's goal is precise site neutrality between the physician office and the non-excepted off-campus PBD, CMS could achieve this goal for services with professional/technical component splits by paying the PFS technical component to the applicable off-campus sites since there are only non-facility RVUs under the PFS. The dilemma that CMS faces is how to determine the non-facility rate for non-imaging codes that do not have a separate non-facility technical component relative value. Therefore, the proposed 2018 relativity adjustor methodology is not directly applicable to codes with at PC/TC split and instead would underpay a good portion of these services under the PFS rate.

The ACR recommends that if CMS does not have the data from the –PO modifier to use for analysis and proposals to determine a different percentage of OPPS for off-campus sites, CMS should keep the policy at 50% of OPPS until you do have such data. We also believe that a comparison of HOPPS rate to the TC of the MPFS rates is not realistic for radiology. Radiology has experienced so many cuts in the –TC of the PFS since 2006, including the reduced hourly rate of the physician practice information data, cuts as a result of the deficit reduction act, reductions as a result of the multiple procedural payment reduction policy and changes to the equipment utilization rate. The reason that radiologists can no longer own their imaging centers is because they cannot cover their costs. No physician group can take financial risk in offering services in the office setting at a loss. If CMS wants to price off-campus sites at

the –TC of the PFS rate or lower, they may find that these sites will also not be able to cover their costs and will not continue to exist. Once any office or hospital site has closed, it is financially difficult to reopen them if the payment scenario were to improve.

Conclusion

The ACR appreciates the opportunity to provide comments on the CY 2018 MPFS proposed rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process in order to create a stable and equitable payment system. The ACR looks forward to continued dialogues with CMS officials about these and other issues affecting radiology and radiation oncology. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Kathryn Keysor at 800-227-5463 ext. 4950 or via email at kkeysor@acr.org.

Respectfully Submitted,

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