RBMA
Radiology Business
Management Association

January 27, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1601-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8013

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

Dear Administrator Tavenner:

The Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the final rule for the CY 2014 Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgical Center (ASC) Payment System 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.

****

## Comments on Specific Issues in the Final Rule

Calculation and the Use of Cost-to-Charge Ratios (CCRs) (*Federal Register* page 74840)

**While RBMA appreciates CMS' decision to exclude hospital claims based on the square-foot allocation method for assigning costs from its derivation of CCRs for CT and MRI for four years, our concerns remain with respect to: (1) separate CCRs for CT and MRI and (2) HOPPS payment cuts to CT and MRI.**

In the CY 2014 HOPPS proposed rule, CMS contemplated new CCRs for CT and MRI for calculating Ambulatory Payment Classification (APC) weights. RBMA opposed these new CCRs for CT and MRI based on the following arguments: (1) estimated costs and HOPPS payments lack face validity, (2) hospital cost accounting can be inaccurate, and (3) that the cost reports should meet minimum data quality standards.

In the final rule, CMS announced its plans to implement separate CCRs for CT and MRI for CY 2014. However, the agency modified its calculation of these CCRs by removing claims from hospitals that use the square foot allocation method through CY 2017. 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 employed.

RBMA
Radiology Business
Management Association

RBMA appreciates CMS' flexibility in modifying its CCR methodology to exclude hospital claims that utilize the square-foot allocation approach. This correction improved the cost estimates for CT and MRI APCs by 6.4 to 17.7 percent.[1]

Despite CMS' modified approach, the CY 2014 CCRs for CT and MRI are lower than the single radiology CCR used through 2013. As the following analysis shows, the APC payment weights for CT and MRI are between 7.9 to 28.5 percent lower than in 2013. These payment cuts are significant in their magnitude and still lack face validity.

| | | 2014 | | 2013 | | Percentage Change 2014 vs. 2013 | |
|---|---|---|---|---|---|---|---|
| APC | Group Title | Relative Weight | Payment Rate | Relative Weight | Payment Rate | Relative Weight | Payment Rate* |
| 0282 | Miscellaneous Computed Axial Tomography | 1.0948 | $79.56 | 1.3864 | $98.87 | -21.0% | -19.5% |
| 0283 | Computed Tomography with Contrast | 3.4263 | $249.00 | 4.1669 | $297.15 | -17.8% | -16.2% |
| 0284 | Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast | 5.8687 | $426.49 | 6.3741 | $454.56 | -7.9% | -6.2% |
| 0331 | Combined Abdomen and Pelvis CT without Contrast | 3.3271 | $241.79 | 4.2917 | $306.05 | -22.5% | -21.0% |
| 0332 | Computed Tomography without Contrast | 1.7403 | $126.47 | 2.4340 | $173.58 | -28.5% | -27.1% |
| 0333 | Computed Tomography without Contrast followed by Contrast | 3.8584 | $280.40 | 4.6182 | $329.34 | -16.5% | -14.9% |
| 0334 | Combined Abdomen and Pelvis CT with Contrast | 5.3683 | $390.13 | 6.7671 | $482.58 | -20.7% | -19.2% |
| 0336 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast | 4.0563 | $294.78 | 4.7466 | $338.49 | -14.5% | -12.9% |
| 0337 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast | 6.7828 | $492.92 | 7.7051 | $549.47 | -12.0% | -10.3% |
| 8005 | CT and CTA without Contrast Composite | 4.2148 | $306.30 | 5.6130 | $400.28 | -24.9% | -23.5% |
| 8006 | CT and CTA with Contrast Composite | 7.5446 | $548.28 | 9.5649 | $682.10 | -21.1% | -19.6% |
| 8007 | MRI and MRA without Contrast Composite | 8.5494 | $621.30 | 9.9120 | $706.85 | -13.7% | -12.1% |
| 8008 | MRI and MRA with Contrast Composite | 12.7618 | $927.43 | 14.5688 | $1,038.94 | -12.4% | -10.7% |

**The difference in the impacts between the relative weight and payment rate is likely due to the CY 2014 update to the HOPPS conversion factor.*

Moreover, because of the Deficit Reduction Act (DRA) of 2005 which caps the Medicare Physician Fee Schedule (MPFS) technical component (TC) payments for advanced imaging services to the lesser of the MPFS or HOPPS rates, the CY 2014 APC rates for CT and MRI may result in further payment cuts to the TC of CT and MRI. Since 2006 Medicare's payment to imaging has been cut at least 12 times and most of these cuts have affected the

[1] *Federal Register*, Vol. 78, No. 237, Table 4, page 74846

technical component. Physician practices and imaging centers are not going to understand why this technical change in HOPPS results in additional payment cuts to non-hospital imaging centers. For these reasons, RBMA strongly encourages the agency to separately evaluate the impacts of implementing any additional CCRs under the HOPPS as part of future rulemaking.

HOPPS Treatment of New CPT and Level II HCPCS Codes (*Federal Register* page 74963)

**CMS' assignment of the new bundled CPT codes for breast interventions (19081-19086; 19281-19288) into CY 2014 APCs results in dramatically lower HOPPS payments.**

Breast biopsies and other forms of image-guided minimally-invasive procedures are important diagnostic tools for patients with suspicious breast lesions. CPT created 14 new codes to describe these image-guided, minimally-invasive breast procedures that combined both the procedure and the imaging-guidance (e.g., ultrasound, stereotactic mammography, and MRI). Yet, the assignment of these codes to their CY 2014 APCs has caused payment reductions averaging 40 percent from 2013 levels. RBMA is uncertain why these established procedures would suffer such significant payment reductions and we, respectfully, ask CMS for clarification and reconsideration.

* * *

The RBMA appreciates the opportunity to comment on CMS' CY 2014 Hospital Outpatient Prospective Payment System 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: Liz Richter, CMS
Marjorie Baldo, CMS
Erick Chuang, CMS