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August 16, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule; CMS-1503-P

Dear Administrator Berwick:

The American Association of Physicists in Medicine[1] (AAPM) is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 13, 2010 *Federal Register* notice regarding the 2011 Medicare Physician Fee Schedule (MPFS) proposed rule. AAPM will provide comments on the 2011 MPFS update, 2011 practice expense proposals, potentially misvalued codes, expanding the multiple procedure payment reduction (MPPR) policy, high cost supplies and disclosure requirements for the in-office ancillary service exception.

Physician Fee Schedule Update for 2011

A. Rebasing the Medicare Economic Index

CMS proposes to rebase and revise the Medicare Economic Index (MEI) and incorporate it into the 2011 MPFS update. CMS proposes to rebase the MEI to 2006 utilizing more updated information to more accurately reflect physicians' practice costs. AAPM supports this proposal and agrees that CMS should periodically rebase and revise the index to reflect more current conditions than the current base year of 2000. Further, AAPM supports an increased adjustment factor to the practice expense and malpractice relative value units.

AAPM recommends that CMS fully implement the Medicare Economic Index (MEI) proposal for the 2011 Medicare Physician Fee Schedule update.

[1] The American Association of Physicists in Medicine's (AAPM) is the premier organization in medical physics, a broadly-based scientific and professional discipline encompassing physics principles and applications in biology and medicine whose mission is to advance the science, education and professional practice of medical physics. Medical physicists contribute to the effectiveness of radiological imaging procedures by assuring radiation safety and helping to develop improved imaging techniques (e.g., mammography CT, MR, ultrasound). They contribute to development of therapeutic techniques (e.g., prostate implants, stereotactic radiosurgery), collaborate with radiation oncologists to design treatment plans, and monitor equipment and procedures to insure that cancer patients receive the prescribed dose of radiation to the correct location. Medical physicists are responsible for ensuring that imaging and treatment facilities meet the rules and regulations of the U.S. Nuclear Regulatory Commission (NRC) and various State regulatory agencies. AAPM represents over 7,000 medical physicists.

B. Sustainable Growth Rate and Proposed 2011 Conversion Factor

In the 2011 MPFS proposed rule, CMS projects a 6.1 percent reduction to physician payment rates in 2011 due to the application of the sustainable growth rate (SGR) formula. The current estimate of the 2011 conversion factor is $26.6574, which yields a total 28 percent reduction to the current 2010 conversion factor of $36.8729.

While we understand that CMS is required by law to update the conversion factor on an annual basis according to the SGR formula, AAPM does not support reductions under the SGR system forecasted for 2011 and subsequent years. The SGR formula is unreasonable and does not accurately reflect the health care costs of treating Medicare patients. Further, the current formula does not account for the costs and savings associated with new technologies. The current SGR formula must be replaced with one where payment updates keep pace with practice cost increases.

AAPM continues to recommend that CMS replace the sustainable growth rate with an annual update system like those of other provider groups so that payment rates will better reflect actual increases in physician practice and freestanding cancer center costs and take into account Medicare Part B savings associated with new technologies.

Proposed Practice Expense Revisions for 2011

A. Equipment Utilization Rate

AAPM supports the current 50 percent equipment utilization rate assumption for all medical equipment, including linear accelerators, stereotactic radiosurgery systems, stereotactic body radiation therapy equipment and Gammaknife units used in therapeutic radiation to treat cancer. The therapeutic use of radiation to treat cancer should not be the focus of those concerned with volume growth in advanced diagnostic imaging.

B. HCPCS Code-Specific Practice Expense Proposals

1. Cobalt-57 Flood Source

AAPM supports the CMS proposal to change the useful life of the Cobalt-57 flood source (ER001) from 5 years to 2 years.

2. Equipment Duplication

AAPM supports the CMS proposal to remove an additional pulse oximeter with printer (EQ211) from stereotactic surgery code 77371.

3. Establishing Overall Direct Practice Expense Supply Price Inputs Based on Unit Prices and Quantities

AAPM supports the CMS proposal to correct the price of Micropore surgical tape (SG079) for stereotactic radiosurgery codes 77371, 77372 and 77373.

C. Updating Equipment and Supply Price Inputs for Existing Codes

AAPM supports the CMS proposal to update equipment and supply price inputs for existing codes through the annual rulemaking process. We believe that the CMS proposal is transparent and would be subject to public review and comment.

Potentially Misvalued Codes Under the Physician Fee Schedule

CMS identified potentially misvalued codes on the multispecialty points of comparison (MPC) list for 2011, including code 77300 *Basic radiation dosimetry calculation*. We understand that CPT 77300 was recently reviewed by the AMA Relative Value Update Committee (RUC) during the third 5-year review. Since this code was recently RUC-reviewed, AAPM suggests that CMS focus its efforts on other types of potentially misvalued codes.

AAPM does not recommend re-validation of CPT 77300 or any other codes on the multispecialty points of comparison list for 2011, including 77290 and 77334.

Services on the MPS list have the highest level of RUC validation of any services in the MPFS. AAPM believes that the CMS request for re-validating any codes on the MPC list is inappropriate.

Proposed Expansion of the Imaging Technical Component Multiple Procedure Payment Reduction Policy to Additional Combinations of Imaging Services

Effective January 1, 2011, CMS proposes to apply the multiple procedure payment reduction (MPPR) regardless of family, that is, the policy would apply to multiple imaging services furnished within the same family of codes or across families. CMS states that this proposal would simplify the current imaging MPPR policy in a way that is consistent with the MPPR policy for surgical procedures that does not group procedures by body region. Therefore, the MPPR would apply to CT and CTA, MRI and MRA, and ultrasound procedures services furnished to the same patient in the same session, regardless of the imaging modality, and not limited to contiguous body areas.

AAPM does not support the CMS proposal to expand the multiple procedure payment reduction (MPPR) policy to the technical component of diagnostic imaging services.

CMS uses the analogy of the 50 percent surgical discount as the justification of this proposal. This is a poor analogy to apply to imaging services with "XXX" global periods. The surgical MPPR generally applies to 90-day surgical procedures because there is duplication of work and practice expense in preservice office visits, postoperative hospital care and postoperative hospital visits. We believe that the 50 percent discount is more difficult to justify for services with shorter global periods.

Further, there is no credible data to support the supposition that substantial efficiencies exist when diagnostic and other ancillary services are performed together. The current mandate discounts the second and subsequent imaging procedures by 50 percent. AAPM does not believe that there is that level of efficiency when two services are provided in the same session and even less duplication when these imaging services are provided in separate sessions on the same day.

Future Updates to Prices of High Cost Supplies

CMS describes a refined process for regularly updating prices for high cost supplies ($150 or more) under the MPFS and solicits comments on how they could improve the process. CMS notes that they would propose the refined process through rulemaking before revising the prices for any high cost supply item based on the General Services Administration (GSA) schedule process. CMS states that the updating process could occur every 2 years beginning as soon as 2013.

AAPM urges caution in utilizing the GSA supply schedule pricing as an alternative to the current CMS practice expense database. We agree that the GSA is one source to establish supply costs but it should not be considered the only source. Further, there is concern that pricing high cost supplies based on the GSA supply schedule could result in loss of relativity in practice expenses because pricing for low cost supplies would be otherwise determined.

In the proposed rule, CMS states that if a supply price were not publicly available on the GSA medical supply schedule by the time the Agency needs to access the price, CMS would propose to reduce the current price input for the supply by a percentage that would be based on the relationship between GSA prices at that time and the existing practice expense database prices for similar supplies (currently an average 23 percent reduction). We would oppose a blanket 23 percent reduction to these supply costs and believe the reduction should be validated on a code-by-code basis.

Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

Section 6003 of the Patient Protection and Affordable Care Act creates a new disclosure requirement for the in-office ancillary services exception to the prohibition on physician self-referral. Specifically, the disclosure requirement applies to advanced diagnostic imaging services including CT, MRI and PET. In the proposed rule, CMS states that they are considering expanding the disclosure requirement to other radiology and imaging services. AAPM supports expansion of the disclosure requirements to include radiation oncology services. We believe that full disclosure of physician-owned radiation therapy equipment may alleviate some of the current abuses of the in-office ancillary services exception policy.

AAPM recommends that CMS consider expanding the self-referral disclosure requirements to include radiation oncology services for future rulemaking.

Conclusion

Appropriate payment for radiology and radiation oncology procedures and medical physics services is necessary to ensure that Medicare beneficiaries will continue to have full access to imaging in the diagnosis of cancer and high quality cancer treatments in freestanding cancer centers. We hope that CMS will take these issues under consideration for the 2011 Physician Fee Schedule final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 637-6060.

Sincerely,

James Goodwin, M.S.
Chair,
Professional Economics Committee

Lena Lamel, M.S
Vice-Chair
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CC: Carol Bazell, M.D., M.P.H., CMS