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August 26, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1524-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 2012; Proposed Rule; CMS-1524-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 19, 2011 *Federal Register* notice regarding the 2012 Medicare Physician Fee Schedule (MPFS) proposed rule. AAPM will provide comments on the 2012 radiation oncology proposed relative value units, geographic practice cost index proposals, expanding the multiple procedure payment reduction policy and review of potentially misvalued codes.

Proposed Reductions to 2012 Radiation Oncology RVUs

AAPM has reviewed the proposed relative value units (RVUs) for radiation oncology codes 77261-77799 and notes that almost all of these codes will incur RVU reductions in 2012. In fact many codes will realize reductions greater than 10 percent and four radiation oncology codes have slated reductions greater than 25 percent (see below):

- CPT 77295-TC (3D simulation) -19.8%
- CPT 77305-TC (isodose plans) -14.0%
- CPT 77310-TC (isodose plans) -12.3%
- CPT 77321-TC (special teletherapy port plan) -15.9%
- CPT 77333-TC (treatment device) -25.0%
- **CPT 77336 (weekly medical physics consult) -13.0%**

[1] The American Association of Physicists in Medicine (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.

- CPT 77401 (superficial radiation therapy delivery) -14.7%
- CPT 77470-TC (special treatment procedure) -28.3%
- CPT 77605-TC (deep external hyperthermia) -29.4%.
- CPT 77610-TC (interstitial hyperthermia) -25.8%

This proposed rule includes extreme, unpredictable shifts in payment for numerous services in the MPFS. AAPM is concerned that the published fully implemented practice expense RVUs for many services have significantly changed from previous years' estimates for fully implemented practice expense RVUs for the same services. As the transition of practice expense nears completion, it is inappropriate to see these dramatic shifts. It is unclear to us why the impact of the practice expense transition on radiation oncology appears to be fluctuating, and we would appreciate CMS addressing this issue in the 2012 MPFS final rule.

AAPM is also concerned regarding faulty data used to determine the practice expense per hour (PE/HR). It appears that the PE/HR for radiation oncology was $291.30 in the 2010 final rule and 2012 proposed rule and $327.06 in the 2011 final rule (see attachment 1). Although this may be a CMS technical or clerical error, we are unsure if this is the cause of RVU reductions in the 2012 proposed rule.

In addition, we understand that the methodology for determining the PE/HR for radiation oncology involves weighting the proportion of time physicians spend on services in hospital versus non-hospital settings, and blending hospital-based PE/HR with non-hospital PE/HR accordingly. We believe that radiation oncology services continue to shift from hospital to non-hospital settings and request that the "blend" of freestanding and hospital-based PE/HR data be re-weighted accordingly.

> **AAPM requests that CMS further study the proposed 2012 practice expense RVU reductions for radiation oncology codes 77261-77799 and provide additional analysis and explanation in the 2012 Medicare Physician Fee Schedule final rule.**

AAPM is concerned regarding further RVU reductions in 2013, the final year of the 4-year transition to utilizing the AMA Physician Practice Information Survey data. Based on the 2012 proposed rule impact tables, radiation oncology will yield an overall 8 percent reduction and radiation therapy centers an overall 9 percent reduction to 2013 payments based on CMS practice expense proposals.

Radiation Oncology and Radiation Therapy Centers have the largest negative impacts to <u>both</u> 2012 and 2013 total payments compared to all 57 specialties. Continued reductions to RVUs and MPFS payments will have a deleterious effect on freestanding cancer centers and impact the provision of cancer care, especially in rural areas. Medicare beneficiaries deserve access to quality cancer treatment provided in freestanding and community-based cancer centers.

> **AAPM recommends that CMS stabilize radiation oncology RVUs and payments in order to ensure Medicare beneficiary access to life saving cancer treatments provided in freestanding and community-based cancer centers.**

Geographic Practice Cost Index Proposals

CMS proposes to revise the practice expense geographic practice cost indices (GPCI) for each Medicare locality, as well as the cost share weights for all three GPCI components. Specifically, CMS proposes to refine the occupations that it uses to calculate geographic differences in employee compensation to consider wages of professional and non-professional staff in a medical office. CMS proposes to utilize wage data from the Bureau of Labor Statistics Occupational Employment Statistics (BLS OES) specific to the office of physicians' industry.

AAPM has concerns regarding utilization of the BLS OES data because this data includes no information regarding wages for medical physicists. Health physicist data is used instead. It is imperative that the practice expense GPCI contain accurate data that reflects the wages and compensation of a medical physicist. Wages and compensation of a health physicist do not reflect professional staff in a physician office or freestanding cancer center setting.

Medical physicists contribute to the effectiveness of radiological imaging procedures by assuring radiation safety and help to develop improved imaging techniques. They contribute to development of therapeutic techniques (e.g., prostate implants, stereotactic radiosurgery), collaborate with radiation oncologists, 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.

Enclosed for your review and consideration is the latest AAPM salary data from 2010 that reflects accurate and up to date information regarding medical physicist wages (see attachment 2). **The average 2010 median salary for a certified medical physicist was $183,950 exclusive of benefits,** which is based on the average median salary of a certified M.S. degree medical physicist ($176,700) and a certified Ph.D. degree medical physicist ($191,200) on pages 10 and 12 of the report, respectively. This data should be included in the development of the practice expense GPCI for 2012.

> **AAPM recommends that CMS incorporate the 2010 certified medical physicist salary wage of $183,950 in the 2012 practice expense GPCI calculation.**

Proposed Expansion of the Multiple Procedure Payment Reduction Policy to the Professional Component of Advanced Diagnostic Imaging Services

Effective January 1, 2012, CMS proposes to apply the multiple procedure payment reduction (MPPR) to the professional component of advanced diagnostic imaging services, including CT and CTA, MRI and MRA, and ultrasound procedures furnished to the same patient in the same session. CMS bases this proposal on the expected efficiencies in furnishing multiple services in the same session due to duplication of physician work, primarily in the pre- and post-service periods, with smaller efficiencies in the intra-service period. CMS proposes to make full payment for the highest paid imaging procedure, and payment would be reduced by 50 percent for the second and subsequent imaging procedures furnished to the same patient in the same session.

The American College of Radiology (ACR) recently conducted a study to assess potential physician work efficiencies when more than one diagnostic imaging study is interpreted by the same provider in the same session. The study concluded that in many situations providing multiple services to the same patient during the same encounter may actually be more complex and less efficient, especially when treating trauma victims, cancer patients and those with acute

coronary syndromes or surgical abdomens. In these cases, clinical condition complexity increases pre- and post-service work.

In addition, the ACR concluded that any potential efficiencies in physician work in such multiservice settings are highly variable, not only between imaging modalities but also within modality families, and are considerably less than those previously estimated by government accountants and policymakers. For example, the maximum percentage of potentially duplicated pre-service and post-service activity varied from 19 percent for nuclear medicine services to 24 percent for ultrasound, significantly less than the 50 percent proposed by CMS.

AAPM does not believe that CMS should arbitrarily impose systematic payment reductions policies that are methodologically flawed. Based on the ACR study, while there may be some potential physician work efficiencies when interpreting more than one diagnostic imaging study in the same session, they do not warrant an across the board 50 percent payment reduction to all imaging modalities for the second and subsequent imaging procedures.

> **AAPM does not support the CMS proposal to expand the multiple procedure payment reduction policy to the professional component of diagnostic imaging services, including CT, CTA, MRI, MRA and ultrasound.**
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> **Further, if CMS does implement expansion of the MPPR policy to the professional component of advanced diagnostic imaging services, the second and subsequent imaging study payment reductions should be significantly less than a 50 percent payment reduction.**

Further Expansion of the MPPR Under Consideration for Future Years

CMS states that they are aggressively looking for efficiencies in other sets of codes and will consider implementing more expansive reduction policies in 2013 and beyond. CMS is soliciting public comment on the following MPPR policies, which are under consideration:

- Apply the MPPR to the TC of All Imaging Services
- Apply the MPPR to the PC of All Imaging Services
- Apply the MPPR to the TC of All Diagnostic Tests

AAPM feels strongly that any further expansion of the MPPR policy is unwarranted and unfair. We recommend that CMS continue to work with the RUC on this issue.

Potentially Misvalued Codes Under the Physician Fee Schedule

CMS is proposing a public process to submit codes for review and potential revaluation. Specifically, CMS is proposing that stakeholders may nominate potentially misvalued codes by submitting the code with supporting documentation during the 60-day public comment period following the release of the annual MPFS final rule with comment period. CMS is soliciting public comment on this proposed code nomination process and will consider any suggestions to modify and improve the proposed process.

While the public process outlined by CMS in the 2012 proposed rule provides the public an opportunity to nominate procedures for review, it does not provide a mechanism for entities that are not represented on the AMA Relative Value Update Committee (RUC) to provide ongoing input into the RUC review process itself, nor does it assure RUC consideration of the materials or data provided by entities that are unrepresented. This is especially critical with respect to practice expense inputs, since associations that do not have a “seat at the table” (such as

AAPM) may have significant information regarding practice expenses that is not available to the specialty representatives who do have input into RUC deliberations. Medical physicists are extremely knowledgeable regarding non-physician clinical labor time, medical equipment and supplies that are utilized in radiation oncology procedures, especially those services that utilize a medical physicist or dosimetrist.

> **AAPM is supportive of an open and transparent public process to submit procedure codes for review as potentially misvalued, however, we suggest that CMS consider the issue of how to provide entities, such as AAPM, that are not represented on the AMA Relative Value Update Committee (RUC) an opportunity to provide input into the review process.**

In addition, CMS proposes to consolidate the formal Five-Year Review of Work and Practice Expense with the annual review of potentially misvalued codes. While the AAPM does not oppose consolidation of the Five-Year Review of Work and Practice Expense with the annual review of potentially misvalued codes, we ask that CMS proceed with caution when selecting potentially misvalued codes for review by specialty.

As you know, many professional societies do not have adequate staff or volunteer member resources to conduct multiple physician work and practice expense surveys per year. Larger professional specialty societies with a greater number of procedure codes often do not have the staff or volunteer member resources to conduct a large number of surveys per year. CMS should consider a cap on the maximum number of potentially misvalued codes reviewed within a specialty in one year, so that the administrative burden is not onerous.

In addition, based on limited professional society staff and volunteer member resources, we recommend that a code designated by CMS for review not be eligible for a second or additional review for a period of at least three years.

> **AAPM recommends that CMS modify the potentially misvalued code review process to cap the maximum number of codes for annual review within a specialty and limit a second review or additional review of a specific CPT code for a period of three years.**

Conclusion

Appropriate payment for medical physics services and radiation oncology and radiology procedures 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 2012 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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