



GE Healthcare

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August 31, 2009

Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-1413-P  
P.O. Box 8013  
Baltimore, MD 21244-1850.

**ATTN: FILE CODE CMS-1413-P**

**Re: Medicare Program; Payment Policies Under the Physician Fee  
Schedule and Other Revisions to Part B for CY 2010.**

Dear Ms. Frizzera:

GE Healthcare (GEHC) appreciates this opportunity to comment on the proposed rule with comment period issued by the Centers for Medicare and Medicaid Services (CMS) concerning changes to the Medicare Physician Fee Schedule for calendar year 2010 (Federal Register, Vol. 74, No. 132, July 13, 2009) (Proposed Rule).

GEHC, a \$17 billion unit of General Electric Company that is headquartered in the United Kingdom, has expertise in medical imaging and information technologies, medical diagnostics, patient monitoring systems, performance improvement, drug discovery, and biopharmaceuticals manufacturing technologies. GEHC's broad range of products and services enables healthcare providers to offer patients earlier and better diagnosis and treatment of cancer, heart disease, neurological diseases, and other conditions that threaten the quality and length of life. Worldwide, GEHC employs more than 46,000 people committed to serving healthcare professionals and their patients in more than 100 countries.

### **Overview of Comments**

Our comments focus on the following issues:

- **Cumulative impact of current and proposed changes on imaging services:** GEHC urges CMS to consider the breadth and cumulative effect of recent changes on reimbursement levels for diagnostic imaging and the potential detrimental impact on beneficiary access to imaging, especially during this current period of economic recession.

GEHC strongly urges CMS to consider new and rigorous data from Direct Research LLC and the National Bureau of Economic Research that confirms the fact that increased utilization of

imaging cannot be attributed to a simplistic assumption of Medicare overvaluation of these services, but rather reflects the value of imaging and its contribution to quality and safety of care, and improved life expectancy.

- **Proposed increase in utilization factor assumption in practice expense RVU formula:** GEHC strongly urges CMS to retain the current utilization assumption, which is supported by new actual data on equipment usage from the 2009 Radiology Business Management Association (RBMA) study that assessed actual usage and the Medical Imaging and Technology Alliance (MITA) pilot study. Given the potential for a more robust data collection methodology using Radiology Information Systems (RIS), which are present in over 75 percent of hospitals and 50 to 60 percent of non-hospital imaging providers, we urge CMS to not implement changes in the utilization rate based on inaccurate data. Fundamentally, without the availability of actual data on usage, the Balanced Budget Act of 1997 requirement for such “actual data” indicates that CMS does not, in fact, have the statutory authority to finalize the proposed 90 percent usage rate. The MedPAC 2006 and the IMV data analyses on which this proposal is based are flawed and do not provide accurate and current actual data on equipment usage rates required to make changes to the utilization rate assumption. If, in the future, CMS proposes a new equipment usage rate based on actual data, such data and the related implementation components (i.e. selection of equipment price thresholds, definitions of equipment price, process for updating equipment prices) should be addressed in a future rulemaking and be open for public comment.
- **Use of Physician Practice Information Survey (PPIS) for Practice Expense Data:** GEHC has serious concerns about the quality of the PPIS data compared to the existing radiology supplemental survey, and believes that use of the PPIS data should be delayed until it is made transparent and further analysis of its precision is performed. We urge CMS to use the same precision requirements applied to prior supplemental surveys. We believe that the AMA has made significant effort towards generating more current data to support the PE calculation; however, we believe this initial effort should be improved upon prior to fully integrating the results into the practice expense calculation.
- **Misvalued Services:** GEHC recommends that any pricing data that CMS proposes to use in the future be available for public comment so that stakeholders can evaluate and provide feedback to the agency, on the pricing information’s accuracy and timeliness, as well as the practical availability of the supply item itself.

GEHC urges CMS to approach packaging with caution. In evaluating such combinations, we encourage CMS not to use the 75 percent rule as the only criterion for evaluating the potential for multiple procedure discounts. We believe it is important that any such review be accompanied by robust procedures that include examination of clinical rationales that are transparent and open to stakeholder participation.

- **Practice Expense RVUs for CPT 93306:** We respectfully request that CMS revisit the calculation of the PE RVUs for CPT 93306 to reflect the same methodology applied in CY2009. To maintain consistency in costing methodologies for ultrasound services, we believe that an “echocardiography room” should be included in the direct cost inputs for all echocardiography services.

- **Physician Quality Reporting Initiative (PQRI) Measures:** GEHC strongly supports CMS's interest in advancing policies for reporting and measuring the quality of physician services. Imaging, diagnostic monitoring and EHR technologies can play an important role in quality improvement, not only in helping diagnose patients with disease, but also in reducing the need for costly medical services and invasive surgical procedures.

We also strongly support CMS's decision to finalize only those measures that have been endorsed by the National Quality Forum (NQF) or another organization that meets the definition of a voluntary consensus standards body, according to NTTAA and OMB Circular No. A-119 (OMB A-119). We recommend that CMS apply NQF (or another voluntary consensus standards body) endorsement not only to individual measures, but also to measure groups.

- **PQRI Reporting Processes using Registries and Electronic Health Records (EHR):** GEHC agrees with CMS's approach to retain the registry reporting option for 2010 and to include use of EHR submission during 2010, if feasible. We agree strongly with CMS that it is important to move away from dependence on claims-based data. Increased use of registries and EHRs will enhance the types and value of measures that can be used for PQRI.
- **Expanded Reporting Process for E-Prescribing Program:** GEHC agrees with CMS's approach to move away from dependency on claims-based data to report on e-prescribing and to allow use of registry and EHR reporting. We agree with the simplification of using one G code and also with the proposal to shift from a percentage of e-Prescribing measure to one that establishes a minimum reporting threshold of 25 times during the 2010 reporting period.
- **Transition to Value-Based Purchasing (VBP) for Physician Services and Other Practitioners:** GEHC agrees with CMS's general objectives for VBP and appreciates CMS's efforts to engage comments through public listening sessions such as the one held in December 2008. We encourage CMS to continue to host such public forums on various aspects of physician VBP prior to submitting its report to Congress in 2010. GEHC believes that a transparent and consensus-building process, with substantial provider input, will be instrumental to the success of the program in the long run. We further urge that CMS ensure that its development of quality and performance measurement systems proceeds in a way that matches the rigorous needs associated with value-based payment, especially for physician-based VBP, given that PQRI is not as mature as the hospital quality reporting program. In addition, we urge that CMS coordinate with implementation of the ARRA HITECH incentives to encourage use of EHRs and HIT to empower physicians to meet VBP goals through such tools as point-of-care clinical decision support and internal quality measure feedback systems.
- **Accreditation Requirements for Suppliers of Advanced Imaging Services:** We appreciate CMS's focus on the current list of advanced imaging services and believe the list is appropriate. We also appreciate CMS contemplating that there will be a number of different accreditation organizations for advanced imaging services.
- **Proposal to Remove Physician-Administered Drugs from Sustainable Growth Rate (SGR) Formula:** GEHC supports CMS's proposal to remove physician-administered drugs from the computation of the SGR formula.

## Detailed Comments

### Cumulative Impact of Current and Proposed Changes on Imaging Services

In recent years, several regulatory and legislative changes have been implemented that greatly impact the Medicare Physician Fee Schedule (MPFS). This included the Deficit Reduction Act (DRA), effective in CY2007, which mandated that reimbursement for imaging procedures paid under the MPFS be capped at the rate paid under the Medicare Hospital Outpatient Prospective Payment System (HOPPS). In the first year after DRA caps on imaging payment were implemented, the rate of growth of claims for imaging services slowed dramatically, and total payment for imaging services under the Medicare physician fee schedule fell 19.2 percent.<sup>1</sup> In an earlier 2008 study, the GAO estimated that in 2007, the implementation of the DRA cap resulted in a reduction of 11.1 percent in spending on physician imaging services.<sup>2</sup> CMS should not implement further payment reductions until it has fully assessed the effects of the DRA caps. Rushing forward with the proposed changes could adversely affect access to appropriate imaging and radiation therapy services.

Also in CY2007, CMS began the transition to payment rates based on a revised practice expense methodology. CY2010 is the final year of this phase-in. As a result of this change in methodology, many imaging procedures have experienced a high degree of instability. In addition to these downward pressures on reimbursement rates, CMS continues to employ a reduction in payment of 25% for subsequent procedures performed on contiguous body parts in a single session for designated families of multiple imaging services.

In addition, several other regulatory changes have increased the “cost” of participating in Medicare. For example, starting in CY2009, CMS required that certain mobile diagnostic testing services comply with the performance standards of independent diagnostic testing facilities (IDTF).<sup>3</sup> Also, as will be discussed later, suppliers of advanced diagnostic imaging services will be required to be accredited by January 1, 2012. Costs of securing accreditation are expected to be significant.

These cumulative reductions in reimbursement for imaging experienced since CY2007 are now aggravated by several more proposed reductions to reimbursement for imaging. These include the introduction of the Physician Practice Information Survey (PPIS) data to estimate indirect practice expenses and the proposed increase in the utilization factor assumption from 50% to 90% for equipment greater than \$1 million. Not only will these proposed changes result in yet additional reductions to reimbursement, they will also be implemented during a period of severe economic recession.

**We urge CMS to consider the breadth and cumulative effect of all these changes on reimbursement levels for diagnostic imaging and the potential detrimental impact on beneficiary access to imaging, especially during this current period of economic recession. We also urge CMS to provide mechanisms that provide for equitable payment levels, enable stability in payment rates, and yield transparency in payment determinations. Clearly, these reductions may discourage use of clinically important imaging services.**

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<sup>1</sup> The Moran Company. *Trends in Physician Imaging Services Billed to Part B Medicare Carriers and Paid under the Medicare Physician Fee Schedule: 1998-2007*, Moran Company analysis for the Access to Medical Imaging Coalition, March 2009.

<sup>2</sup> GAO. *Medicare: Trends in Fees, Utilization, and Expenditures for Imaging Services before and after Implementation of the Deficit Reduction Act*. GAO-08-1102R. September 2008.

<sup>3</sup> Federal Register. Vol 73. No 224. November 19, 2008. (MPFS Final Rule CY2009)

Underlying many of the recent payment reductions for imaging services is the assumption made by the Medicare Payment Advisory Commission (MedPAC) that the growth in imaging services is a reflection of overvalued resource-based payment amounts for these services.<sup>4</sup> This assumption is also supported by CMS. However, a recent study by Direct Research, LLC indicates that high rates of imaging growth are a reflection, not of Medicare overpayment, but rather of technological innovation in diagnostic imaging that has improved the quality and safety of existing procedures and created new applications for these procedures.<sup>5</sup> This study found high rates of imaging growth across all payers and internationally. Among Medicare providers, growth in imaging occurred in both hospital outpatient departments and physician offices, for both generalists and specialists, for services under self-referral and those not under self-referral, in urban and rural areas, and across all states, indicating that growth in imaging transcends payment systems. This evidence suggests that Medicare payment rates were not the primary cause of rapid spending growth in diagnostic imaging. Instead, the study found strong “regression to the mean” in utilization rates by geography, which is consistent with diffusion of technology into low-use areas. In sum, the evidence indicates that improvements in imaging technology explain the widespread growth in imaging in the U.S. and other countries, rather than the simplistic assumption of Medicare overpayment.

The value of imaging is further confirmed by a recent National Bureau of Economic Research Working Paper which found that life expectancy increased more rapidly in states where the fraction of Medicare diagnostic imaging procedures that were advanced procedures increased more rapidly.<sup>6</sup> Specifically, the study findings suggest that increased use of advanced imaging technology increased life expectancy by 0.62-0.71 years compared to the total increase in life expectancy at birth of 2.37 years during the period 1991 and 2004.

**GEHC strongly urges CMS to consider these new and rigorous data, which confirm that increased utilization of imaging cannot be attributed to a simplistic assumption of Medicare overpayment, but rather reflects the value of imaging and its contribution to quality and safety of care, and improved life expectancy.**

### **Proposed Increase in the Utilization Factor Assumption in Practice Expense RVU Formula**

For the component of the practice expense (PE) methodology associated with the allocation of equipment costs for calculating PE relative value units (RVUs), CMS currently assumes an equipment usage rate of 50 percent. CMS proposes to increase this utilization factor assumption from 50 percent to 90 percent for equipment priced over \$1 million. CMS is not proposing to change the usage rate for less expensive equipment, but is examining data for potential similar changes in the future.

In the proposed CY2010 MPFS rule, CMS cites the 2006 Medicare Payment Advisory Commission (MedPAC) survey of imaging providers in six markets conducted by NORC/Georgetown University as justification for the increased utilization rate. This contradicts CMS’s prior acknowledgement in CY2008 MPFS Final Rule, where CMS stated that the MedPAC data provided insufficient empirical evidence to justify alternative usage percentage assumptions. By its own admission, MedPAC itself

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<sup>4</sup> MedPAC. *Report to Congress: Medicare Payment Policy*. March 2009. p 105. Federal Register. Vol 73. No. 130. July 7, 2008. p. 38586. (MPFS Proposed Rule). p 33532.

<sup>5</sup> Direct Research, LLC. *Analysis of Medicare Imaging Spending Trends, 2002-2007*. July 31, 2009.

<sup>6</sup> Lichtenberg, F. *The Quality of Medical Care, Behavioral Risk Factors, and Longevity Growth*. National Bureau of Economic Research. Working Paper 15068. June 2009.

even cautioned against using its survey to determine equipment use rates. According to transcripts of an April 19, 2006 meeting, MedPAC said: "This survey is a first step...It was not nationally representative and it was not designed to determine equipment use rates. Its intent was to assess the feasibility of getting use rate data from the survey." According to a study by United Biosource Corporation (UBC), the MedPAC survey methods and sampling frame were insufficient to support their use in policy or reimbursement decision-making at a national level.<sup>7</sup> In addition, the data from this survey were collected in 2006, before the DRA caps on imaging payment went into effect. An analysis by Direct Research, LLC found that the volume of MRI services reimbursed under the physician fee schedule declined by 2.2 percentage points from 2006-2007, after the DRA caps were implemented.<sup>8</sup>

Based on its 2006 analysis, MedPAC recommended that CMS adopt a normative standard that assumes that providers use costly machines at nearly full capacity (45 hours per week, or 90 percent of the time that providers are assumed to be open). Importantly, however, MedPAC acknowledges that such changes would require a change in statute because the Balanced Budget Act of 1997 requires CMS to use "actual data" on equipment use to calculate practice expense relative value units (PE RVUs). Specifically, the law states, "the Secretary of Health and Human Services shall develop new resource-based relative value units. In developing such units, the Secretary shall ... (A)(ii) use actual data on equipment utilization and other key assumptions" (Section 4505(d)(1)(A)(ii) of the Balanced Budget Act of 1997 (P.L. 105-33)(42 U.S.C. 1395w-4 note)). As will be shown below, CMS's 90 percent equipment usage rate is not substantiated by actual current data. Hence, CMS has gone beyond its statutory authority in proposing a change in utilization rate from 50 percent to 90 percent without the availability of actual utilization data.

MedPAC also analyzed data from a 2007 survey of non-hospital CT providers by IMV Ltd, a market research firm (IMV Medical Information Division 2008). MedPAC used IMV data to calculate that the average provider uses its CT scanner 50 hours per week, but their calculation was incorrect.<sup>9</sup> Specifically, MedPAC divided the average number of studies per CT reported by IMV (4,165) by IMV's estimate of the number of studies per hour (1.6) to arrive at the conclusion that the average CT is "in use" approximately 50 hours per week (4,165/1.6/52 weeks = 50 hours). The calculation is incorrect because IMV's 1.6 studies-per-hour figure is based on the hours that the CT is "available" for imaging, not the hours that the CT is being used for imaging. To illustrate why this is important, consider a CT that operates 10 hours per day, schedules studies in 30-minute slots, and performs 16 studies per day. Studies per hour would be 1.6, but the actual utilization rate would necessarily be less than 80% (8 hours of scheduled time divided by 10 hours of available time). The actual utilization rate would drop below 80% because patient exams typically finish in less than the allotted time, patients do not show up for appointments, and so on.

New 2009 survey data collected by the Radiology Business Management Association (RBMA), which assessed 261 imaging machines in 46 centers, both rural and urban, shows that, for all modalities, imaging centers in rural areas operate equipment approximately 48% of the time their offices are open; non-rural centers operate equipment during approximately 56% of their office hours.<sup>10</sup> For advanced imaging modalities (CT, MRI, PET, PET/CT, Nuclear Medicine), the study showed an average utilization rate of 60% for all providers. In contrast to CMS's analysis of IMV data, current actual data

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<sup>7</sup> United Biosource Corporation, *Final Report: Evaluation and Critique of MedPAC Survey on MRI/CT Utilization Included as part of MedPAC's June 2006 Report to Congress*. March 9, 2007 and Revised June 26, 2007.

<sup>8</sup> Direct Research, LLC. *Analysis of Medicare Imaging Spending Trends, 2002-2007*. July 31, 2009. p. 16

<sup>9</sup> MedPAC. *Report to Congress: Medicare Payment Policy*. March 2009. p. 108.

<sup>10</sup> Radiology Business Management Association (RBMA). *Imaging Equipment Utilization Rates. Final Report*. June 16, 2009. <http://rightscanrighttime.org/wp-content/uploads/2009/06/sfc-rbma-utilization-rate-excerpt.pdf>

show that no diagnostic modality in a freestanding outpatient center, on average, reaches the 90 percent utilization rate recommended by CMS. In fact, the RBMA data suggests that CMS's current utilization rate of 50 percent is more indicative of actual use.

The Medical Imaging and Technology Alliance (MITA) conducted its own pilot study of data from CT and MR systems, which produced results similar to the RBMA survey. The MITA study collected scan time data from 117 CT systems (6 rural and 92 urban) and 392 MR systems (7 rural and 368 urban).<sup>11</sup> MITA then combined these data with a fixed amount of pre-scan and post-scan service time based on independent, internal time study analysis. The results suggest an average utilization rate of 48 percent for CT (25 percent for rural providers and 52 percent for urban providers) and 70 percent for MRI (50 percent for rural providers and 70 percent for urban providers). These results are consistent with the RBMA's results, although they may reflect a selection bias toward providers with higher utilization rates. The data include all patients and scans, not just Medicare patients who might require more time in the imaging room due to limited mobility and more complex medical conditions, and tend to include providers with newer equipment operating at high efficiency. As a result, the data could overestimate the utilization rate. Moreover, the survey was able to include only a small number of rural providers. Given the large disparity in utilization rates between urban and rural providers, it is critical that more data be collected to solidify utilization rate assumptions.

This survey demonstrates that information technology solutions can collect data that could help CMS establish accurate utilization rates. A more robust data collection methodology could use Radiology Information Systems (RIS), which are present in over 75 percent of hospitals and 50 to 60 percent of non-hospital imaging providers. With cooperation from CMS and providers, as well as additional investment, existing RIS data could be used to provide accurate information on:

- Full procedure time, including time for patient preparation and egress time.
- Access to care in all settings (independent diagnostic testing facilities, offices, and hospital outpatient imaging centers). Key access measures available from RIS data already captured using the DICOM standard include waiting time for an appointment and distance traveled to receive imaging services. Given the potential of this data collection capability, we urge CMS to not implement changes in the utilization rate based on inaccurate data.

CMS does not believe the proposed 90 percent equipment usage rate would create access issues in rural areas. It cites MedPAC's March 2009 Report (p. 110) which stated that according to AHA 2007 data, 95 percent of rural hospitals provide CT services and 79 percent of rural hospitals provide MRI services in their community. Therefore, if rural areas do not have physician offices or freestanding centers with MRI and CT machines, most of these communities have access to such services through a hospital.

GEHC believes that increasing the utilization assumption to a level higher than actual use rates would result in a severe cut for imaging reimbursements that will impair access to diagnostic imaging services. These cuts would have a devastating impact on patients in rural regions of the country, causing congestion and delays at the point of care, and forcing physicians to pull back services in those communities. For example, the MedPAC data cited above also shows that 21% of rural hospitals do not have an MRI machine. CMS's and MedPAC's belief that beneficiaries can receive the same services at local hospitals does not factor in the needs of elderly Medicare patients, where patient handling can be time consuming and proximity to a facility is essential.

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<sup>11</sup> Note that the larger total number includes systems where the urban/rural status could not be determined.

Some aspects of CMS's proposed utilization rate assumption for equipment over \$1 million dollar are unclear. Neither MedPAC nor CMS offer a sound methodology for selecting the equipment price threshold of \$1 million. Based on a table of CMS's estimated purchase price for selected diagnostic imaging equipment, MedPAC appears to arbitrarily pick the \$1 million figure, even though it recognizes that "an important question would be how to define 'costly'".<sup>12</sup> Nor do MedPAC and CMS define what is included in this equipment price which is taken from the CMS direct practice expense file on the CMS website -- a file which includes data as much as six years old.

Clearly, the proposed equipment usage assumption of 90 percent is not supported by actual use data, and is based on arbitrary price thresholds, and undefined, aggregated and potentially outdated equipment prices from the CMS practice expense files. **GEHC strongly urges CMS to retain the current utilization assumption as supported by new actual equipment usage data from the 2009 RBMA study and the MITA pilot study. Given the potential for a more robust data collection methodology using Radiology Information Systems (RIS), which are present in over 75 percent of hospitals and 50 to 60 percent of non-hospital imaging providers, we urge CMS to not implement changes in the utilization rate based on inaccurate data. Fundamentally, without the availability of actual data, BBA (1997) provisions requiring the use of such data lead us to conclude that CMS does not have the statutory authority to finalize the 90 percent usage rate. Further, we believe that the MedPAC 2006 and IMV data analyses on which the 90% assumption is based are flawed and do not provide accurate and current actual data on equipment usage rates. If, in the future, CMS proposes a new equipment usage rate based on actual data, such data and the related implementation components (i.e. selection of equipment price thresholds, definitions of equipment price, process for updating equipment prices) should be addressed in a future rulemaking and be open for public comment.**

### **Use of Physician Practice Information Survey (PPIS)**

Currently, CMS uses the practice expense per hour (PE/HR) data obtained from the Socioeconomic Monitoring System (SMS) surveys from 1995-1999. For several specialties that collected additional PE/HR data through a more recent supplemental survey, CMS accepted and incorporated these data in developing current PE/HR values. As required by the [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106-113) (BBRA), CMS established a process by which specialty groups could submit supplemental data. With respect to imaging services, CMS currently uses the supplemental data for radiology and independent diagnostic testing facilities.

CMS proposes to update PE/HR using new data from a survey conducted by the American Medical Association (AMA) -- the Physician Practice Information Survey (PPIS). The PPIS, administered in CY2007 and CY2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs. According to CMS, the PPIS is a multispecialty, nationally representative practice expense survey of both physicians and non-physician practitioners using a consistent survey instrument and methods highly consistent with those used for the SMS and supplemental surveys. The PPIS has gathered information from 3,656 respondents across 51 physician specialty and health professional groups.

CMS is intending to use this data to set payment for radiology services such that the indirect percentage for radiology would increase from 58 percent to 71 percent. These shifts from direct to

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<sup>12</sup> MedPAC. *Report to Congress: Medicare Payment Policy*. March 2009. p 109.

indirect PE, combined with significant reductions in PE/hour for radiology (down 19 percent from \$118.48 to \$95.60) produce large reductions in the PE RVUs for these services.<sup>13</sup> Since independent diagnostic testing facilities (IDTFs) did not participate in PPIS, CMS proposes to continue to use the current PE/HR that was developed in prior supplemental data.

Notably, the BBRA required CMS to establish criteria for accepting supplemental survey data. Since the supplemental surveys were specific to individual specialties and not part of a comprehensive multispecialty survey, CMS required certain precision levels be met in order to ensure that the supplemental data was sufficiently valid, and to be accepted for use in the development of the PE RVUs. CMS believes that because the PPIS is a contemporaneous, consistently collected and comprehensive multispecialty survey, it is not necessary to have similar precision requirements and has not established them for the use of the PPIS data.

GEHC is very concerned about the accuracy and representativeness of the data since CMS has decided not to apply its stated criteria for supplemental survey data to the PPIS data. The PPIS data has not been made available to stakeholders for analysis; hence, we are unable to examine differences between its results and those of existing supplemental surveys. It is not apparent from the description of the survey's respondents that PPIS produces accurate data. In comparison, the SMS study was conducted at a practice level and completed by the business manager with broad experience, included a shorter survey instrument, and generated responses from 170 out of 187 surveys; the PPIS survey is not as representative or precise. The data files posted on CMS's website indicate that only a few dozen completed surveys were used to calculate the PE/hour data for most specialties. For example, the figure in the "number of completes" column for PE/hour for radiology is 56, the figure for interventional radiology is 33, the figure for radiation oncology is 71, and the figure for nuclear medicine is only 16. Thus, it appears that data supplied by an extremely small number of respondents would be used to set payment rates for all services performed by these specialties. CMS also notes, "the survey responses were adjusted for non-response bias,"<sup>14</sup> but it does not provide information allowing verification of the accuracy of this adjustment. Moreover, the data appear to reflect a bias against specialties and services that require intense use of equipment. Yet these are precisely the specialties that need to be protected from erratic swings in payment rates from year to year as they need predictability to make investments in capital equipment, protecting beneficiary access to state-of-the-art medical care.

Whenever a new data source could produce dramatic reductions in the underlying data for the PE RVUs, CMS should take particular care to ensure that the data are accurate. We urge CMS not to implement the new PE RVUs calculated using the PPIS data. A delay would allow time for analysis to check the validity of the data. Clearly there is critical need to allow for transparency in the data. If CMS insists on using the new data, the agency should phase in the new RVUs using a blend of SMS and PPIS data over at least four years to allow physicians time to adjust to the changes in payment rates and to give CMS time to identify any anomalies in the data, as it did when it implemented the new PE RVU methodology.

**In sum, GEHC has serious concerns about the quality of the PPIS data compared to the existing radiology supplemental survey, and believes that use of the PPIS data should be delayed until it is made transparent and further analysis of its precision is performed. We urge CMS to use the same precision requirements applied to prior supplemental surveys. We believe that the AMA has made significant effort towards generating more current data to support the PE calculation;**

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<sup>13</sup> Federal Register, Vol. 74, No. 132, July 13, 2009. pp 33530-31. (MPFS Proposed Rule CY2010)

<sup>14</sup> Id. p. 33531.

however, we believe this initial effort should be improved upon prior to fully integrating the results into the practice expense calculation.

### Misvalued Services

In the CY2010 PFS Proposed Rule, CMS identifies several mechanisms for addressing potentially misvalued services including: (a) Update of prices associated with high cost supplies; and (b) Review of services often billed together for the purpose of potentially expanding the multiple procedure discount to additional non-surgical procedures. With respect to item (a) *Update of prices associated with high cost supplies*, CMS is not proposing any actions at this time and will continue to examine alternatives on the best way to obtain accurate pricing information. **GEHC recommends that any pricing data that CMS proposes to use in the future be available for public comment so that stakeholders can evaluate and provide feedback to the agency on the pricing information's accuracy and timeliness, as well as the practical availability of the supply item itself.**

With respect to item (b): *Review of services often billed together*, CMS is not proposing any specific actions at this time, but is proposing to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. **GEHC urges CMS to approach packaging with caution. Packaging obscures Medicare's payments for individual services, preventing stakeholders from understanding the rate calculations. Furthermore, GEHC believes that when different services are frequently provided in combination with each other, there are clinical judgments and patient-specific circumstances that influence when such services should be provided together or separately. In evaluating such combinations, we encourage CMS not to use the 75 percent rule as the only criterion for evaluating the potential for multiple procedure discounts. We believe it is important that any such review be accompanied by robust procedures that include examination of clinical rationales, are transparent and open to stakeholder participation.**

### Practice Expense RVU for CPT 93306

In CY2009, the AMA introduced CPT 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography* a code which combined the services of the primary code CPT 93307 *Echocardiography, transthoracic, real-time with image documentation (2D), include M-mode recording, when performed, complete, without spectral or color Doppler echocardiography* with frequently billed add-on codes CPT 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging)* and CPT 93325 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, follow-up or limited study (List separately in addition to codes for echocardiographic imaging)*.

In the CY2009 proposed rule, the fully implemented practice expense RVU for the non-facility technical component of CPT 93306 was 5.1, which was consistent with the sum of the PE RVUs for the technical component of the three codes.

| CPT Codes<br>CY2009<br>Descriptions | Final CY2009 Fully<br>Implemented Non-Facility<br>Practice Expense RVU <sup>15</sup> | Proposed CY2010 Fully<br>Implemented Non-Facility<br>Practice Expense RVU <sup>16</sup> |
|-------------------------------------|--|---|
| <b>CPT 93306</b>                    | <b>5.1</b>   | <b>2.49 (Proposed CMS)<br/>4.20 (Recommended RVU)</b>                                   |
| <i>CPT 93307</i>                    | <i>3.10</i>  | <i>2.45</i>   |
| <i>CPT 93320</i>                    | <i>1.40</i>  | <i>1.10</i>   |
| <i>CPT 93325</i>                    | <i>0.60</i>  | <i>0.47</i>   |

For CY2010, CMS proposes a practice expense RVU for the non-facility technical component of CPT 93306 equal to 2.49. This value is far less than the sum of the PE RVUs for the non-facility technical component of the three codes, which is 4.02. **We believe that this is a technical error and respectfully request that CMS revisit the calculation of the PE RVUs for CPT 93306 to reflect the same methodology applied in CY2009.**

We also note that echocardiography services are the only ultrasound services that do not include an “ultrasound room” as a direct cost input. For example, the direct cost inputs for general ultrasound services include a “general ultrasound room” and the direct cost inputs for vascular ultrasound services include a “vascular ultrasound room.” **To maintain consistency in costing methodologies for ultrasound services, we believe that an “echocardiography room” should be included in the direct cost inputs for all echocardiography services.** Our understanding is that the applicable cost data has been submitted by the relevant professional societies.

### Physician Quality Reporting Initiative (PQRI) Measures

For CY2010, CMS proposes to add 22 individual PQRI measures and six measure groups. Following Medicare Improvement Patients and Providers Act (MIPPA), CMS would also allow group practices to qualify for the PQRI incentive.

Section 183 of MIPPA requires that quality measures be selected by the Secretary from measures that have been endorsed by the entity under contract with the Secretary under subsection 1890(a) of the Act. Since the National Quality Forum was awarded this contract, CMS states that, except in certain specified cases, each proposed 2010 PQRI quality measure would need to be endorsed by the NQF by July 1, 2009.

**GEHC strongly supports CMS’s interest in advancing policies for reporting and measuring the quality of physician services. Imaging, diagnostic monitoring and EHR technologies can play an important role in quality improvement, not only in helping diagnose patients with disease, but also in reducing the need for costly medical services and invasive surgical procedures.**

<sup>15</sup> Medicare Physician Rule File CY2009. RVU File “RVU09C”. Accessed at CMS website <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&intNumPerPage=10> (last accessed August 17, 2009)

<sup>16</sup> Federal Register, Vol 74. No. 132, July 13, 2009. pp. 33787. (MFPS Proposed Rule CY2010)

**We also strongly support CMS's decision to finalize only those measures that have been endorsed by the NQF or a similar organization that meets the definition of a voluntary consensus standards body, according to NTTAA and OMB Circular No. A-119 (OMB A-119).. We recommend that CMS apply NQF endorsement not only to individual measures, but also to measure groups.**

### **PQRI Reporting Processes using Registries and Electronic Health Records (EHR)**

For 2010 PQRI, CMS is proposing to retain the claims-based reporting mechanism and the registry-based reporting mechanism. It proposes to add an electronic health record (EHR)-based reporting mechanism to promote adoption and use of EHRs, contingent upon the successful completion of CMS's 2009 EHR data submission testing and development of a practical and feasible process. Under the rule, CMS would begin accepting data from qualified EHR products on ten proposed individual PQRI measures. Eligible participants would be able to count their submission of EHR-based measures towards their eligibility for a PQRI incentive payment. In 2010, CMS proposes that participants who satisfactorily report data on at least three of these ten proposed EHR-based individual PQRI measures be eligible for an incentive payment. In the past, EHR has not counted towards the eligibility payment.

**GEHC agrees with CMS's approach to retain the registry reporting option and to include use of EHR submission during 2010, if feasible. We agree with CMS strongly that it is important to move away from dependence on claims-based data. Increased use of registries and EHRs will enhance the types and value of measures that can be used for PQRI. We understand that the provisions in this proposed rule do not implement any aspects of the Health Information Technology for Economic and Clinical Health (HITECH) Act provision of the American Recovery and Reinvestment Act (AARA); nevertheless, we agree that use of EHR-based measure data (directly from an EHR or via a registry) will provide invaluable experience and serve as a foundation for establishing the capacity for eligible professionals to send, and for CMS to receive, data on quality measures via EHRs.**

**In addition, we suggest the following:**

- **Allow submission of computed measures from registries and EHRs rather than requiring submission of only detailed patient level data.**
- **We suggest that CMS look for alternatives to claims-based or encounter-based reporting for structural measures, such a those focusing on use of Information Technology. The direction proposed for e-Prescribing reporting in this NPRM is a good example of such a shift.**
- **We agree with the development of a group practice reporting option as required by statute. We do urge caution on reporting on group level performance until CMS is fully satisfied with the validity and reliability of the performance data collected for groups under the new methods.**

### **Expanded Reporting Process for E-Prescribing Program**

For CY2010, CMS is proposing three reporting mechanisms for participating eligible professionals (a) claims-based reporting, (b) EHR-based reporting, or (c) qualified registry reporting.

In addition, CMS proposes to modify numerator reporting by establishing only one G code, G8443, to indicate that at least one prescription in connection with the visit billed was electronically prescribed. That is, CMS proposes to eliminate the two remaining G-codes from the measure's numerator: G8445 (no prescriptions were generated during the visit) and G8446 (some or all prescriptions were written or phoned in due to patient request, State or Federal law, the pharmacy's system being unable to receive the data electronically or because the prescription was for a narcotic or other controlled substance).

CMS is also proposing that, instead of identifying successful electronic prescribers for a reporting period based on the eligible professional's reporting of the electronic prescribing measure in at least 50 percent of applicable cases, the eligible professional would be required to report at least one prescription for a Medicare Part B FFS patient created during an encounter at least 25 times during the 2010 reporting period. The proposed minimum reporting threshold of 25 is based on the notion that an eligible professional would need to e-prescribe, on average, for approximately two Medicare Part B FFS patient encounters per month during the reporting period in order to be considered a successful e-prescriber.

**GEHC agrees with CMS's approach to move away from dependency on claims-based data to allow use of registry and EHR reporting. We agree with the simplification of using one G code and also with the proposal to shift from a percentage of e-Prescribing measure to one that establishes a minimum reporting threshold of 25 times during the 2010 reporting period.**

### **Transition to Value-Based Purchasing (VBP) for Physicians and Other Practitioners**

Section 131(d) of the MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing program for Medicare payment for covered professional services made under, or based on, the PFS. By May 1, 2010, the Secretary is to submit a report to the Congress, containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Building on input from the Listening Session on the Issues Paper topics (December 9, 2008 Listening Session), the Physician and Other Health Professional VBP (PVBP) Workgroup has begun to develop potential recommendations for inclusion in the Report to Congress.

According to CMS, its first step is to design various approaches for performance-based payment that will address the planning goal and objectives for different practice arrangements. This design process will include identifying appropriate measures and incentive structures, considering the necessary data infrastructure, and addressing public reporting options. Consideration will be given to approaches that: (1) Overlay the current PFS, such as differential fee schedule payments based on measured performance or for providing a medical home; (2) Address multiple levels of accountability, including individual health professionals, as well as larger teams or organizations; and (3) Promote more integrated care through shared savings models and bundled payment arrangements.

**GEHC agrees with CMS's general objectives for VBP and appreciates CMS's efforts to engage comments through public listening sessions such as the one held in December 2008. We participated in this meeting and found it very helpful. We encourage CMS to continue to host such public forums on various aspects of physician VBP prior to submitting its report to Congress in 2010. GEHC believes that a transparent and consensus-building process, with substantial provider input, will be instrumental to the success of the program in the long run. We further urge that CMS ensure that its development of quality and performance measurement systems**

proceeds in a way that matches the rigorous needs associated with value-based payment, especially for physician-based VBP, given that PQRI is not as mature as the hospital quality reporting program. In addition, we urge that CMS coordinate with implementation of the ARRA HITECH incentives to encourage use of EHRs and HIT to empower physicians to meet VBP goals through such tools as point-of-care clinical decision support and internal quality measure feedback systems.

### **Accreditation Requirements for Suppliers of Advanced Imaging Services**

Pursuant to the Medicare Improvements for Patients and Providers Act of 2008, the Proposed Physician Fee Schedule contemplates a new § 414.68 (Imaging accreditation) that addresses the approval and removal of independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component of advanced diagnostic imaging services. **At the outset, we appreciate CMS's focus on the current list of advanced imaging services and believe the list is appropriate. We also appreciate CMS contemplating that there will be a number of different accreditation organizations for advanced imaging services.**

CMS included certain accreditation cost assumptions in the preamble of the Proposed Rule and stated that "the estimated average cost per year would be approximately \$1,666." This estimate is only based upon accreditation fees and does not, for example, include the cost associated with coming into initial compliance, preparing for a survey, responding to surveyor requests for information and the like. CMS acknowledged that there are "other accreditation costs", including initial compliance and survey preparation, but concluded that such cost "should result in minimal preparation and cost." **We believe the cost of compliance and preparation will be substantial and likely more than the costs of the accreditation fees. Therefore, we suggest that CMS refine its cost estimates to include not only the cost associated with accreditation fees but also the costs associated with accreditation, including the costs of initial compliance, survey preparation, responding to surveyor requests for information, and other costs.**

The Proposed Physician Fee Schedule also provides for validation audits whereby CMS or its contractor may conduct an audit of an accredited supplier to "validate the survey accreditation process of approved accreditation organizations." In the preamble to the Proposed Rule, however, CMS provided that: "If a supplier selected for a validation audit failed to comply with the requirements at § 414.68, the supplier would not longer meet the Medicare requirements and, under this proposal, the supplier's accreditation for the TC of advanced imaging services would be revoked."

This raises a number of questions in terms of differences in interpretations between CMS, the approved accreditation organizations, and each of their contractors and surveyors. While CMS has afforded accreditation organizations certain notification, reconsideration and hearing rights as a result of the validation audits, CMS has not addressed whether these due process rights will also be afforded to the accredited suppliers. Lastly and in terms of the timing for the revocation of the accreditation of the supplier, Section 1834 (e) (2) (C) (ii) of the Social Security Act (Act) provides suppliers with certain protections. **Therefore, we suggest that CMS establishes a process whereby suppliers are provided with due process rights. Alternatively, CMS could confirm that suppliers are entitled to use an existing CMS appeals mechanism. We also suggest that CMS confirm that suppliers are afforded certain protections under the Act.**

The accreditation standards for suppliers of advanced imaging services are included in MIPPA and in the Proposed PFS. **To the extent that CMS issues additional regulations or provides guidance**

**(e.g., surveyor guidelines) on the accreditation standards, we encourage CMS to pursue an open and transparent process with substantial opportunity for public review and comment.**

### **Proposal to Remove Physician-Administered Drugs from Sustainable Growth Rate (SGR) Formula**

CMS notes that the statutory definition of “physicians’ services” for purposes of the SGR (section 1848(f)(4)(A) of the Act) includes other items and services specified by the Secretary, that are commonly performed by a physician or in a physician’s office. CMS believes that given the significant and disproportionate impact that the inclusion of items such as drugs has had on the SGR system, it would be appropriate to revise the definition of physicians’ services for purposes of the SGR. CMS believes the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of “physicians’ services.” Therefore, CMS is proposing, in anticipation of enactment of legislation to provide fundamental reforms to Medicare physician payments, to remove physician-administered drugs from the definition of “physicians’ services” in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years. Also, CMS believes it is reasonable to remove drugs from the calculation of allowed and actual expenditures for all prior years.

Under this proposal, removing physician-administered drugs from allowed and actual expenditures for all prior years will not change the projected -21.5 percent physician payment rate update for services furnished on or after January 1, 2010. This proposal would, however, reduce the past discrepancy between actual and target expenditures. As a result, it would reduce the number of years in which physicians are projected to experience a negative update.

**GEHC supports CMS’s proposal to remove physician-administered drugs from the computation of the SGR formula. GEHC believes that although such drugs are integral to a physician service, the prices of these items do not follow the same resource-based formula used for professional services; hence, it is appropriate to remove them in the calculation of the update factor for professional services. Also, this change will help reduce the deviation between target and actual spending and improve future updates to physician payments under the Medicare physician fee schedule.**

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GEHC very much appreciates the opportunity to submit comments on these important issues. If you have any questions on our comments, please do not hesitate to contact me at [hubert.zettel@ge.com](mailto:hubert.zettel@ge.com).

Sincerely,



Hugh Zettel  
Strategic Reimbursement Executive