



SOCIETY FOR VASCULAR ULTRASOUND

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August 29, 2008

Kerry Weems, Acting Administrator  
Centers for Medicare and Medicaid Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

RE: CMS-1404-P: Medicare Program: Proposed Changes to the  
Hospital Outpatient Prospective Payment System and CY  
2009 Payment Rates

Dear Acting Administrator Weems:

The Society for Vascular Ultrasound ("SVU") thanks the Centers for Medicare and Medicaid Services ("CMS") for this opportunity to comment on the Proposed Changes to the Hospital Outpatient Prospective Payment System ("HOPPS") and CY 2009 Payment Rates (the "Proposed Rule").<sup>1</sup> The SVU is a professional society comprised of over 4,300 vascular technologists, sonographers, nurses, and physicians who provide a variety of high-quality vascular ultrasound services to Medicare beneficiaries. Increasingly, hospital outpatient departments employ ultrasound testing as the sole examination prior to surgical and other interventions, not only saving Medicare dollars, but also reducing the risks involved with other invasive modalities which present much more significant morbidity and mortality risks. With this in mind, SVU offers comments to the Proposed Rule regarding the reporting of costs and charges and the calculation of cost-to-charge ratios ("CCRs") for diagnostic radiology services.

Specifically, we write to express our appreciation and strong support for CMS's proposal to create standard cost centers for Computed Tomography ("CT") Scanning and Magnetic Resonance Imaging ("MRI") and, by extension, other diagnostic radiology procedures. The creation of standard cost reporting lines for CT Scanning, MRI, and other diagnostic radiology procedures is necessary to ensure more accurate reimbursement for radiology services. The utilization of separate CCRs for high markup procedures such as MRI and CT Scanning, and low markup procedures such as ultrasound, is necessary to avoid the significant problem of "aggregation bias" for

<sup>1</sup> 73 Fed. Reg. 41416 (July 18, 2008).

radiology services, so as to ensure more appropriate reimbursement for imaging services in both the hospital outpatient and physician office settings.

SVU and other interested stakeholders have long expressed deep concern that the use of a single radiology cost center and CCR has been responsible for inappropriately reducing ultrasound reimbursement, particularly vascular ultrasound reimbursement, below the cost of providing those services. Having raised our concerns years before the introduction of payment caps under the Deficit Reduction Act of 2005 ("DRA"),<sup>2</sup> we were disturbed to have our concerns about aggregation bias confirmed by CMS's independent expert, RTI International ("RTI"), in its July 2008 report.<sup>3</sup> Indeed, at this point, should CMS not address the aggregation bias by adopting the proposal, such a failure would fundamentally threaten the integrity of HOPPS and violate the Administrative Procedures Act ("APA"). The need for action along the lines of the CMS proposal is underscored by the fact that a recent study conducted by SVU and the Society of Vascular Surgery established that, since implementation of the DRA, more than 10% of vascular ultrasound providers surveyed reported reducing or eliminating vascular ultrasound services provided to Medicare beneficiaries.

The July 2008 RTI report provides objective support for the concerns that we have raised, with increasing urgency, over a number of years. RTI explained in the report that the aggregation of services with systematically different markup rates to create a single average CCR results in cost estimates for component services with higher markup rates (or lower CCRs) being overstated, and estimates for component services with lower markup rates (or higher CCRs) being understated.<sup>4</sup> Thus, where procedures with different markup rates are reimbursed using a single average CCR, payment is significantly biased towards component services with higher markup rates.

With respect to radiology services, aggregation bias results in procedures with high markups such as CT Scanning and MRI being overpaid, and procedures with lower markups such as ultrasound being underpaid by Medicare. Importantly, RTI noted that combined radiology CCRs pose special problems because "the gap between markup rates for CT and/or MRI and other radiology services is unusually large," and "CT scanning and MRI services comprise a very large portion of total radiology charges."<sup>5</sup>

Thus, in order to ensure adequate reimbursement for ultrasound and other lower markup procedures, CMS should establish standard cost reporting lines for CT Scanning and MRI, in order to ensure that hospitals break out their costs and charges for these high markup services from other diagnostic radiology procedures. CMS's

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<sup>2</sup> Pub. L. 109-171.

<sup>3</sup> RTI International, *Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights (July 2008)*, available at <http://www.rti.org/reports/cms/> (last visited Aug. 25, 2008).

<sup>4</sup> *Id.* at 1.

<sup>5</sup> *Id.* at 113. RTI notes that many common CT scanning and MRI procedures are overstated by 10 to 15 percent.