September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

Re: Medicare Program: Payment Policies under the Physician Fee Schedule; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release for Calendar Year 2018; Proposed Rule 1676-P

Dear Ms. Verma:

We are writing in response to the Calendar Year (CY) 2018 Medicare Physician Proposed Rule, published July 21, 2017 in Federal Register Vol. 82 No. 139 p. 33950. The Society of Nuclear Medicine and Molecular Imaging’s (SNMMI) more than 17,000 members set the standard for molecular imaging and nuclear medicine practice by creating guidelines, sharing information through journals and meetings, and leading advocacy on key issues that affect molecular imaging and therapy, research and practice. We appreciate the opportunity to provide comments to assist the Centers for Medicare and Medicaid Services (CMS) in further refining the MPFS.

We offer comments and recommendations on the following topics addressed in this Proposed Rule:

- Misvalued codes
- Section 603 Off-Campus Provider-Based Department Proposals
- Appropriate Use Criteria
- Reducing Regulatory Burden

**Misvalued Codes**

CMS had identified three nuclear medicine CPT services; 78300, 78305 and 78306 Bone and/or joint imaging as potentially misvalued. The SNMMI along with ACR surveyed these codes and presented to the RUC, the RUC in turn made recommendations to CMS to maintain the current work values. CMS proposes to accept the RUC recommendation to maintain the work relative values in CY 2018. SNMMI commends CMS for accepting these recommendations.
Recommendation: The SNMMI recommends CMS finalize the RUC and specialty society recommendations for work and practice expense for 78300, 78305 and 78306.

Section 603 Off-Campus Provider-Based Department Proposals

Section 603 of the Bipartisan Budget Act of 2015 requires that items and services furnished in new off campus provider-based departments will not be covered by OPPS payment rates beginning January 1, 2017. SNMMI appreciates that most longstanding facilities were exempted from this rule. For CY 2017, CMS finalized the Medicare Physician Fee Schedule (MPFS) as the applicable payment system for most of these items and services. Originally the mechanism to calculate allowed amounts used the OPPS rate reduced by 50. CMS now proposes to change the MPFS payment rates for these services from 50 percent of the OPPS payment rate to 25 percent of the OPPS rate. The OPPS rate is incomplete data for setting rates in the off-campus non-exempted provider based office setting. CMS has only selected the highest volume procedures for the analysis and for the decision to set rates at 25% of the OPPS rate. Additionally, they are comparing a fee schedule rate that does NOT include bundling to a bundled payment. For instance, one nuclear medicine code selected as a high volume service is 78452. While this is a high volume service, it also is one of the highest scrutinized and packaged procedure codes. Not only does this service in HOPPS contain a bundled/packaged diagnostic radiopharmaceutical, it also has a packaged/bundled stress agent and a stress test. If you are comparing the cost of 78452 in HOPPS to the FULL costs in MPFS-PO, CMS must gather all the packaged code items and add them back in to the MPFS rates for a true comparison. So CMS has artificially significantly reduced the rates for these procedures but not including complete data. Using just part of the MPFS payment rates to calculate new OPPS rates is an inappropriate comparison for any nuclear medicine procedure.

Additionally, along with the comparison of apples to oranges data, SNMMI disagrees with CMS’s decision of establishing new site-of-service payment rates under the MPFS to pay non-exempted off-campus provider-based departments (PBDs) for the furnishing of non-exempted items and services. While the society understands the payment policy will utilize all of the claims, SNMMI disagrees with the averaging calculation of 25%. Applying an averaging methodology should equalize payment, however, in another scenario, because the Deficit Reduction Act (DRA) adjustment is already applied, a redundancy occurs for any nuclear medicine procedure that is already adjusted by the DRA. For example, this methodology would impact all of the PET imaging procedures (CPT codes 78459, 79491, 78492, 78608, and 78811-78816). SNMMI recommends that CMS consider applying an exemption where DRA would be applied to specific CPT codes and to consider that this policy does not apply to nuclear medicine services because they are not comparing all the packaged cost data from the MPFS for an accurate comparison and a false percentage calculation. Applying a redundant equalization method to these services undervalues the payment rate for these services and will shift patient care back to the hospital setting, ultimately creating patient access issues. SNMMI recommends
CMS either create an exemption for codes that fall into the redundancy equalization scenario (as previously mentioned) or utilize the carrier priced rate.

**RECOMMENDATION:** Therefore, SNMMI recommends that CMS exempt all Nuclear Medicine and all DRA affected imaging services from the 25% reduction. Additionally, CMS should also exempt carrier priced services from the 25% reduction and conduct code or family analysis so as to not cause access issues or shifting of care due to insufficient payment rates for important nuclear medicine services.

**Appropriate Use Criteria (AUC)**

CMS is proposing to implement the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging in a manner that allows practitioners more time to focus on and adjust to the Quality Payment Program. The Agency expects a voluntary reporting period to begin prior to January 1, 2019, possibly in July 2018, depending on the readiness of the Medicare claims system to accept and process claims that include AUC consultation information. During this first year, CMS is proposing to pay claims for advanced diagnostic imaging services regardless of whether they contain information on the required AUC consultation. SNMMI commends CMS for implementing the program slowly and methodologically. The society believes this approach will benefit both clinicians and the agency, giving both groups adequate time to prepare for this new program. SNMMI recommends that CMS require providers test claims for a month or conversely, conduct a short pilot to ensure processes are working efficiently and as planned.

**Reducing Regulatory Burden**

Due to the unique nature of nuclear medicine where patients are given radioactive drugs an extremely complex billing system has evolved. This complexity requires and extensive time and training for providers and it must also be a burden for Medicare and its contractors. We question whether the costs of this complexity outweigh the benefit and we suggest that CMS consider performing a cost-benefit analysis of this approach. It may be beneficial to all to simplify billing in this field.

**Conclusion**

SNMMI appreciates the opportunity to comment on the MPFS CY 2018 Proposed Rule to the CMS. As always, SNMMI is ready to discuss any of its comments or meet with CMS on the above issues. In this regard, please contact Caitlin Kubler, Senior Manager, Regulatory Affairs at ckubler@snmmi.org or (703) 326-1190.
Respectfully Submitted,

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President

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