

Specialty	Previous Indirect PE/HR	Final Rule Indirect PE/HR	Previous Indirect %	Final Rule Indirect %
Internal Medicine	\$49.60	84.02	69%	76%
Interventional Pain Medicine	\$59.04	156.79	67%	70%
Interventional Radiology	\$118.48	82.56	58%	81%
Medical Oncology	\$141.84	145.81	59%	59%
Nephrology	\$49.60	66.00	69%	80%
Neurology	\$66.05	110.39	74%	87%
Neurosurgery	\$89.64	115.76	86%	87%
Nuclear Medicine	\$118.48	39.80	58%	77%
Obstetrics/Gynecology	\$69.74	99.32	67%	67%
Ophthalmology	\$103.28	170.07	65%	70%
Optometry	\$59.04	88.02	67%	77%
Oral Surgery (Dentist only)	\$96.01	173.19	71%	65%
Orthopaedic Surgery	\$98.56	131.40	72%	81%
Osteopathic Manipulative Therapy	\$59.04	53.93	67%	93%
Otolaryngology	\$96.01	141.54	71%	75%
Pain Medicine	\$59.04	122.42	67%	70%
Pathology	\$59.80	74.98	70%	74%
Pediatrics	\$51.52	76.27	62%	69%
Physical Medicine and Rehabilitation	\$84.92	110.13	71%	84%
Physical Therapy	\$35.17	57.26	65%	84%
Plastic Surgery	\$99.32	134.81	67%	74%
Podiatry	\$59.04	74.76	67%	82%
Psychiatry	\$29.07	30.10	90%	94%
Pulmonary Disease	\$44.63	55.26	76%	74%
Radiation Oncology (Hospital Based & Freestanding)	\$114.00	165.10	50%	57%
Radiology	\$118.48	95.60	58%	71%
Rheumatology	\$84.92	98.08	71%	67%
Urology	\$119.57	97.01	69%	73%
Vascular Surgery	\$60.10	83.98	63%	73%

c. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we currently perform these calculations with an equipment usage assumption of 50 percent. In the CY 2008 PFS proposed rule (72 FR 38132), we noted that if the assumed equipment usage percentage is set too high, the result would be an insufficient allowance at the service level for the practice costs associated with equipment. If the assumed equipment usage percentage is set too low, the result would be an excessive allowance for the practice costs of equipment at the service level. We acknowledged that the current 50 percent usage assumption does not capture the actual usage rates for all equipment, but stated that we did not believe that we had strong empirical evidence to justify any alternative approaches.

In the CY 2008 PFS final rule with comment period, we summarized comments received on this issue. Commenters' recommendations about making adjustments to the 50 percent utilization rate assumption varied. Some commenters recommended that we do nothing until stronger empirical evidence is available. Other commenters recommended a decrease in the utilization assumption while others recommended an increase in the utilization assumption. We agreed with the commenters that the equipment utilization rate should continue to be examined for accuracy. We

indicated that we would continue to monitor the appropriateness of the equipment utilization assumption, and evaluate whether changes should be proposed in light of the data available.

In the CY 2010 PFS proposed rule (74 FR 33532), we acknowledged that since the publication of the CY 2008 PFS final rule with comment period, MedPAC addressed this issue in its March 2009 Report to Congress (see http://www.medpac.gov/documents/Mar09_EntireReport.pdf).

In part of its discussion, MedPAC stated:

"In 2006, the Commission sponsored a survey by NORC of imaging providers in six markets, which found that MRI and CT machines are used much more than the 25 hours per week that CMS assumes (Table 2B-6). According to data from this survey, MRI scanners are used 52 hours per week, on average (median of 46 hours), and CT machines are operated 42 hours per week, on average (median of 40 hours) (NORC 2006). Although the survey results are not nationally representative, they are representative of imaging providers in the six markets included in the survey. We also analyzed data from a 2007 survey of CT providers by IMV, a market research firm (IMV Medical Information Division 2008). IMV data are widely used in the industry and have also appeared in published studies (Baker et al. 2008, Baker and Atlas 2004). Using IMV's data on 803 nonhospital CT providers (imaging centers, clinics, and physician offices), we calculated that the average provider uses its CT scanner 50 hours per week, which is twice the number CMS assumes. The IMV survey also found that nonhospital providers increased the average number of procedures per CT machine by 31 percent from 2003 to 2007, which indicates that providers either used their machines more hours per day or performed more scans per hour (IMV Medical Information Division 2008)" (p. 108)

In the proposed rule, we stated that the studies cited by MedPAC indicated that the current equipment usage rate assumption is significantly understated, especially with respect to the types of high cost equipment that were the subject of the studies. The current 50 percent utilization rate translates into about 25 hours per week out of a 50-hour work week. The median value of 46 hours for Magnetic Resonance Imaging equipment from the first study cited by MedPAC is equivalent to a utilization rate of 92 percent on a 50-hour week. For Computed Tomography scanners, averaging the value from the first study of 40 hours per week and the value from the second study of 50 hours per week yields 45 hours and is equivalent to a 90 percent utilization rate on a 50-hour work week. Therefore, in the CY 2010 PFS proposed rule, we proposed to increase the equipment usage rate to 90 percent for all services containing equipment that cost in excess of \$1 million dollars. We stated that the studies cited by MedPAC suggested that physicians and suppliers would not typically make huge capital investments in equipment that would only be utilized 50 percent of the time. We stated that we would continue to explore data sources regarding the utilization rates of equipment priced at less than \$1 million dollars, but we did not propose a change in the usage rate for this less expensive equipment.

The following is a summary of the public comments received and our responses.

Comment: We received comments supporting our proposal to apply a 90 percent equipment utilization rate to expensive equipment priced at more than \$1 million and comments opposing our proposal. MedPAC stated:

"The Commission supports CMS's proposal as it applies to diagnostic imaging machines that cost more than \$1 million, and we encourage CMS to explore increasing the equipment use factor for diagnostic imaging machines that cost less than \$1 million. MedPAC did not contemplate applying the policy to radiation therapy machines."

Commenters supporting our proposal cited the MedPAC studies and the rationale we provided in the proposed rule.

Commenters opposing our proposal stated that the Balanced Budget Act of 1997 (BBA) directed CMS to "utilize, to the maximum extent practicable, generally accepted cost accounting principles which: (1) recognize all staff, equipment, supplies and expense, not just those which can be tied to specific procedures; and (2) use actual data on equipment utilization and other key assumptions." The commenters stated that the equipment usage proposal violates this provision of the BBA since we lacked sufficient empirical justification for the change. The

commenters indicated that the National Opinion Research Center survey data, which was one data source used by MedPAC, was not nationally representative, and was never intended to determine equipment usage rates.

Some commenters referenced information submitted by the Radiology Benefit Management Association (RBMA) based on a survey of its members. The commenters stated that the information supported maintaining a 50 percent utilization usage rate assumption for diagnostic imaging equipment. The commenters also stated that the information indicated differences in utilization rates between rural and urban areas and that our proposal would create access issues, especially in rural areas.

In MedPAC's comment letter, it agreed with CMS that "decreasing PE RVUs for expensive diagnostic imaging services should not affect access to care in rural areas."

The AMA submitted summary equipment utilization data from the PPIS survey on MRI, CT, angiography, IMRT, and gamma camera. It stated that although there was a relatively small sample size, the survey responses suggest that equipment utilization varies depending on the type of equipment involved. The AMA requested that we allow specialty societies to provide data supporting lower utilization rates, if appropriate. It stated that this would allow for varying equipment utilization rate

assumptions depending on the type of equipment being used, rather than a single utilization assumption.

Some commenters indicated that even if the available data did indicate a higher utilization rate for certain types of diagnostic equipment, we should not apply the change to all types of expensive diagnostic equipment. For example, we should not apply the usage rate to new imaging technology.

Some commenters requested that we not change the equipment usage rate assumption to 90 percent for any equipment until additional data sources can be identified. The commenters suggested that the equipment usage rate policy should not be limited to increasing usage rate assumptions but should also include potentially decreasing equipment usage rate assumptions when appropriate.

If we were to implement a higher utilization rate, some commenters suggested that the change be phased in over a number of years.

Response: We appreciate all of the comments received on this issue. At the time that we published the proposed rule, we had the data on MRI and CT from the MedPAC analysis. We indicated that the MedPAC studies suggested that physicians and suppliers would not typically make significant capital investments in equipment that would only be utilized 50 percent of the time. Commenters

opposed to our proposal have questioned both the validity of the MedPAC analysis for CT and MRI and extrapolation of this data to all expensive equipment, particularly therapeutic equipment. While we are persuaded by PPIS data on angiography, IMRT, and Gamma Camera that the extrapolation of the MRI and CT data to all expensive equipment may be inappropriate, we disagree with commenters who indicated that we do not have an empirical basis for applying a 90 percent usage rate to MRIs and CTs.

As described earlier, the MedPAC analysis was performed on two data sources for different types of equipment. The first data source was the survey done by NORC for MRIs and CTs. The second data source was the IMV data for CT scans. With respect to MRIs and CTs, we have now also received summary information from the RBMA and summary PPIS survey data from the AMA. The PPIS survey data results for MRIs (n=97) and CTs (n=86) are consistent with the findings from the MedPAC studies on MRIs and CTs. However, the data from the RBMA (17 members submitted a total of 46 center surveys) indicates a lower utilization rate for CT and MRI.

As we have described in section II.A.2.b. of this final rule with comment, the PPIS is the best available data source currently available on PEs. Given the corroboration of the MedPAC analysis by the PPIS data, we

are confident that we are using the best data currently available on the utilization of MRIs and CTs (90 percent), consistent with the BBA requirement that we use actual data on equipment utilization.

We are open to receiving more comprehensive data than the responses of 16 RBMA members on this issue from the RBMA or other members of the public. We will evaluate any data submitted for consideration in future rulemaking.

We continue to agree with the MedPAC analysis and comment indicating that decreasing the PE payments for expensive diagnostic imaging services should not affect access to care in rural areas.

We also agree with commenters that it would be appropriate to transition the new PE RVUs developed using the higher 90 percent utilization rate for MRIs and CTs. As discussed elsewhere in this final rule, we are providing for a 4-year transition (25/75, 50/50, 75/25, 100/0) to the new PE RVUs.

As indicated above, we are not finalizing our proposal to increase the utilization rate assumption for expensive equipment other than MRIs and CTs, including therapeutic equipment. We are finalizing our proposal to increase the utilization rate to 90 percent for expensive diagnostic equipment priced at more than \$1 million.

d. Miscellaneous PE issues