Congress of the United States

Washington, DC 20510

October 25, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure:

We are contacting you regarding reimbursement under the Hospital Outpatient Prospective Payment System (HOPPS) for cardiac computed tomography (CT) services reported using Current Procedural Terminology (CPT©) codes 75572, 75573, and 75574. The recently published CY 2023 OPPS proposed rule again fails to address the flawed methodology that results in inadequate Medicare reimbursement rates for these services, ultimately limiting Medicare beneficiary access to care.

We request that CMS reassign the CPT codes used to bill for coronary computed tomography angiography (CCTA) – 75572, 75573, and 75574 – to ambulatory payment classifications (APCs) that more appropriately reflect the clinical intensity, resource utilization, and cost of these services. We also ask that CMS allow hospitals and practices to submit charges for cardiac CT procedures under revenue codes outside of general CT to improve the accuracy of data used for future cost estimates.

Heart disease is the leading cause of death in the United States. Approximately 655,000 Americans die from heart disease annually – roughly 25% of deaths, despite advances in treatment and diagnostic strategies for coronary artery disease (CAD). Over the past two decades, an effective test for CAD has emerged based on strong clinical science, cost-effectiveness and the ability to positively impact patient outcomes: CCTA. The American College of Cardiology, the American Heart Association, and several other physician societies that treat patients with coronary artery disease (CAD) collaborated to publish new guidelines for the evaluation and diagnosis of chest pain. In these guidelines[1], CCTA received a Class 1 recommendation with level of evidence of A for patients with stable and acute chest pain. It is the only noninvasive test for patients with suspected CAD that received this high level of recommendation. The new guidelines were published in response to overwhelming clinical evidence demonstrating that use of CCTA leads to a 41% lower rate of death and heart attack

[1] Gulati, M., et al., 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation, 2021. 144(22): p. e368-e454.

compared to stress testing[2], allows clinicians to cancel greater than 75% of planned invasive procedures[3], and saves the Medicare program more than $3,100 per patient[4].

Yet, despite multiple guidelines from the U.S. and Europe recommending CCTA as the preferred imaging modality for patients, hospitals have not adopted this service at levels expected for the standard of care. In fact, CMS' own data indicates that Medicare beneficiaries are up to 20 times more likely to receive a stress test. Reimbursement for these costly alternatives is over seven times greater than CCTA, which makes it hard for hospitals to invest in a service line that loses revenue when significantly more profitable alternatives exist[5].

As Members of Congress representing diverse populations across the U.S., we share the administration's concerns regarding health equity and believe that CCTA can help address inequities in cardiac care for communities of color. Studies demonstrate that mortality from cardiovascular diseases, including CAD, is 33% higher for Black individuals compared to the overall population[6] and that Native Americans have a nearly 20% higher cardiovascular mortality rate compared to white individuals[7]. This could be explained by a multitude of factors, including:

- Diagnostic tests that require subjective interpretation (e.g., stress tests) lead to less appropriate care for Black individuals as compared to white individuals[8].
- Racial and ethnic minority groups tend to receive care at safety net hospitals, which perform worse on a wide range of process and outcome measures for cardiovascular conditions[9].
- Black, Hispanic, and Asian patients are more likely to reside in areas with a shortage of physicians and have a lower visit rate to cardiologists compared to white patients[10].
- Black and Hispanic individuals remain at least 30% and 16% less likely, respectively, to receive invasive treatment for CAD compared to white individuals[11].

Multiple studies suggest that implementing guideline-driven care can improve outcomes for racial and ethnic minorities and eliminate the treatment gap[8,11]. CMS has the tools available, through the exercise of the agency's equitable adjustment authority or making an APC

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[2] Newby, D.E., et al., Coronary CT Angiography and 5-Year Risk of Myocardial Infarction. N Engl J Med, 2018. 379(10): p. 924-933.

[3] Maurovich-Horvat, P., et al., CT or Invasive Coronary Angiography in Stable Chest Pain. N Engl J Med, 2022. 386(17): p. 1591-1602.

[4] Douglas, P.S., et al., 1-Year Outcomes of FFRCT-Guided Care in Patients With Suspected Coronary Disease: The PLATFORM Study. J Am Coll Cardiol, 2016. 68(5): p. 435-445.

[5] 2022 OPPS reimbursement for CCTA (CPT 75574) is $182.43 and reimbursement for a nuclear stress test (SPECT, CPT 78451) is $1,334.62.

[6] Lloyd-Jones, D., et al., Heart disease and stroke statistics--2009 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Circulation, 2009. 119(3): p. e21-181.

[7] Veazie, M., et al., Trends and disparities in heart disease mortality among American Indians/Alaska Natives, 1990-2009. Am J Public Health, 2014. 104 Suppl 3(Suppl 3): p. S359-67.

[8] Capers, Q. and Z. Sharalaya, Racial Disparities in Cardiovascular Care: A Review of Culprits and Potential Solutions. Journal of Racial and Ethnic Health Disparities, 2014. 1(3): p. 171-180.

[9] Liu, M., et al., Mortality and Postdischarge Acute Care Utilization for Cardiovascular Conditions at Safety-Net Versus Non–Safety-Net Hospitals. Journal of the American College of Cardiology, 2022. 79(1): p. 83-87.

[10] Cai, C., et al., Racial and Ethnic Disparities in Outpatient Visit Rates Across 29 Specialties. JAMA Internal Medicine, 2021. 181(11): p. 1525-1527.

[11] Mital, R., et al., Race and Ethnicity Considerations in Patients With Coronary Artery Disease and Stroke: JACC Focus Seminar 3/9. Journal of the American College of Cardiology, 2021. 78(24): p. 2483-2492.

reassignment for coronary CT services, to ensure beneficiary access to guideline-driven care and eliminate health inequities in cardiac care.

There is information CMS can point to as support for this exercise of authority in light of the claims data CMS has on CT services. A recent analysis conducted by Braid Forbes Health Research examined the trends in cost and payment for cardiac CT services in the OPPS across the last 12 payment years, including the most recent published figures for the CY 2023 proposed rule. It appears that multiple decisions made by CMS over this period, unrelated to the cost data for cardiac CT services, have had the systematic effect of lowering the payment rate for these services. These decisions include:

- A change in the standard cost center for CT procedures in 2014, which reduced payment by 17%.
- The promotion in 2019 of CPT code 74177 (CT of the abdomen and pelvis) to a higher paying ambulatory payment classification (APC), which reduced payment by 20%.
- The ending in 2020 of a policy using only cost data from hospitals not using square feet as cost allocation statistic, which reduced payment by 10%.

Additionally, a multi-site study comparing direct costs of CCTA (CPT code 75574) to contrast enhanced thoracic CT (CECT, CPT code 71260) found that the direct cost of performing CCTA is significantly higher than CECT, and thus reimbursement schedules that treat these procedures similarly undervalue the resources required to perform CCTA and decrease access to the procedure[12]. Despite the published analysis showing that the hospital resources to furnish CCTA are about 3.4 times greater than the resources required to perform CECT, both codes are assigned to APC 5571 and paid the same rate.

And while CMS has asserted that CCTA does not utilize similar resources as exams assigned to APC 5572, we maintain that there are several procedures in APC 5572 that actually require fewer resources and less time to perform. According to the Society of Cardiovascular Computed Tomography, there are several procedures in APC 5572 that require fewer resources than cardiac CT services, including:

- CPT 72132 - CT lumbar spine with dye
- CPT 73085, contrast x-ray of elbow
- CPT 73115, contrast x-ray of wrist
- CPT 73580, contrast x-ray of knee joint
- CPT 73615, contrast x-ray of ankle
- CPT 74430, contrast x-ray of bladder
- CPT 74177, CT abdomen and pelvis with contrast

These procedures assigned to APC 5572 do not require a special technician, EKG gating, medication prior to or during the exam, monitoring of patients, special software for interpretation, and take less time to perform than a cardiac CT. We hope CMS will closely

[12] Zimmerman, M.E. et al., The direct costs of coronary CT angiography relative to contrast-enhanced thoracic CT: Time-driven activity-based costing. Journal of Cardiovascular Computed Tomography, 2021. 15: pg. 477-483.

examine the resources and time required to perform these procedures relative to those required for cardiac CT.

Finally, to address concerns over the inequities mentioned in cardiac care for communities of color, the following report language was included in the 2023 Labor-HHS Appropriations Bill:

- *Cardiac Computed Tomography (CT)* - The committee notes that unstable and low reimbursement for cardiac CT services is contributing to significant disparity in access to this vital service among minority populations. Within 90 days of enactment, CMS shall report to the committee on what actions are being taken by the agency to address this inequity.

We hope this language will further encourage CMS to focus on this important issue and further examine the health disparities among Medicare beneficiaries resulting from lack of access to cardiac CT – the preferred and guideline-directed imaging modality for patients with suspected CAD.

As CMS maintains the legal authority to modify the APC placement of CPT codes 75572, 75573, and 75574, we hope you will make this much-needed change to increase access, reduce the use of unnecessary tests, and improve health equity all while saving Medicare money. We encourage CMS to put beneficiaries first and support this value-based approach to improve quality, access, and affordability for our constituents.

Thank you for your consideration.

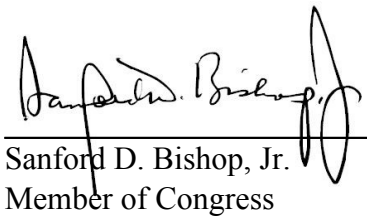
Sincerely,

Ted W. Lieu
Member of Congress

Adrian Smith
Member of Congress

Kim Schrier, M.D.
Member of Congress

Mark E. Amodei
Member of Congress



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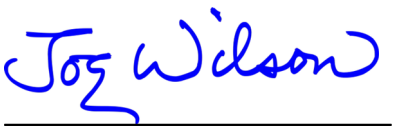

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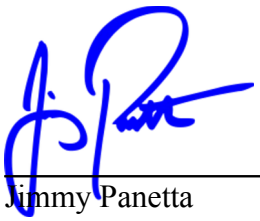

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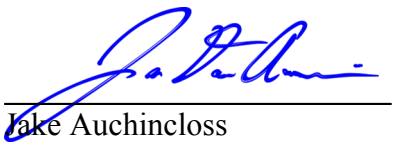

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