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Advocacy for Cardiac CT: The time is now!

"If doctors won't help fix the problems of health care, they shouldn't be outraged when outsiders try to do it for them" (Op-Ed, The New York Times, September 2019)

While the scientific evidence supporting the use of cardiac CT has never been stronger, the adoption of this test into clinical care has been slow. Many factors have influenced the adoption of this technology throughout the world, including access, availability, expertise, and cost of other testing options. In the U.S., it is widely believed that the most dominant force restricting the growth of cardiac CT has been reimbursement.

The U.S. healthcare system has a combination of multiple private and public payors, but the payment rates set by the Centers for Medicare & Medicaid Services (CMS) are the most influential, as other payors often follow these trends. A few points are important to better understand the often-elusive CMS payment system:

1. **Medicare provides separate payments** for the professional component (physician services only) and the technical component (all hospital resources and non-physician services that are used in providing cardiac CT).
2. **While CMS payment rates for cardiac CT codes have been available since 2010, these rates have never represented the actual cost of performing cardiac CT exams** (see Fig. 1). Of significant concern to SCCT members is the fact that the 2020 proposal for the technical component (if implemented) would represent a substantial 33% reduction in payment over a three-year period. Ironically, these cuts are coming at a time when clinical trials and guidelines endorsing cardiac CT have increased.
3. **CMS payment is based on its own "estimated costs" of providing the test, derived from hospital-provided cost and charge data.** Typically, CMS calculates the "estimated cost" by multiplying the charges for each submitted claim by a cost-to-charge-ratio (CCR). The assumption is that if hospitals are getting paid less than what it costs them, they will increase their charges. (Spoiler: this does not happen, especially for low-volume tests.) Increasing the CCR that is used to estimate cost will also increase the "estimated costs". However, cardiac CT must be billed under a CT cost center, and its CCR is determined by cost data that is not based on cardiac CT exams. Consequently, the CCR for cardiac CT is far lower than CCRs used to determine payment for other cardiac imaging tests. Even if hospitals adopted direct cost accounting methods to accurately report costs for all imaging tests, this would not have a meaningful impact on the CMS cost calculation for cardiac CT, which will continue to be diluted by all other hospital-reported CT scan cost data.
4. **Cardiac CT is in the wrong APC!** Cardiac CT is grouped into an ambulatory payment classification (APC) that includes other single-organ CT scans and contrast enhanced x-rays. But according to CMS, tests within a given APC should have similar cost (i.e., resources used to provide the service) and similar clinical purpose — and therefore all tests within an APC are paid the same amount. An SCCT review of CMS data has made it clear that cardiac CT services should be moved to a different APC.

To better understand these issues, and to respond to CMS, SCCT has launched an unprecedented effort. We have hired consultants, purchased and analyzed data that CMS uses for rate-setting, and carefully deliberated with various leaders and healthcare experts. In addition, we have engaged many of our members, as well as other societies, in coordinating a strong response to CMS.

A few highlights of our efforts are noteworthy:

- ☐ SCCT participated in a hearing at CMS at which we had the opportunity to discuss our concerns regarding how current CMS methodology is vastly undervaluing the cost of cardiac CT exams (CPT 75572, 75573, 75574). Through a detailed presentation, we shared with CMS that while cardiac CT exams may use "the same machine," these tests are very different from other types of contrast-enhanced CT exams (i.e. more complex exam, longer scan time, more resources for patient monitoring, need for medication administration, longer image acquisition, longer data reconstruction, need for dedicated software, etc.)
- ☐ We achieved widespread agreement among SCCT, the American College of Cardiology (ACC), and the American College of Radiology (ACR) that all cardiac CT services should move to a different APC (APC 5573) so that payment of these tests will better reflect their true cost. We are very grateful to the ACC and ACR leadership, including Dr. Richard J. Kovacs, and Dr. William T. Thorwarth Jr.
- ☐ Society letters: Multiple strong letters were submitted to CMS, including from ACC, ACR, and NASCI. In addition, ACC submitted a joint letter with SCCT – which represented more than 55,000 cardiologists, radiologists, and other professionals committed to providing quality cardiovascular care.
- ☐ Member letters: Nearly a hundred SCCT members and other healthcare leaders across the country signed letters to CMS, fueled by an unprecedented level of energy and commitment to make a difference in our field. Additionally, the selfless offers of our international leaders and members to write to CMS in support of patient access to this modality were overwhelming.

These efforts represent only the initial steps, and our advocacy committee, SCCT leadership, and our members all have immensely important work ahead. Specifically, we need to continue to work with CMS and with other payors to identify and implement better methods to

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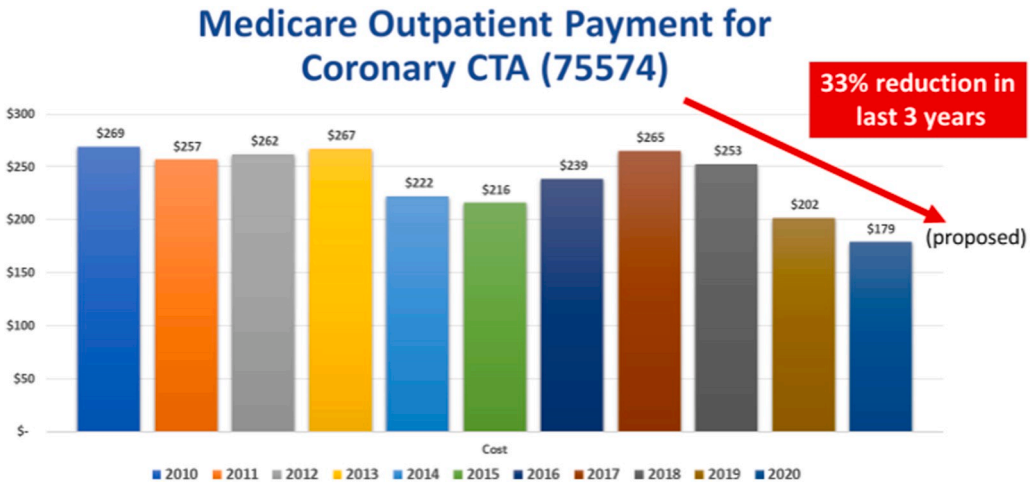

Fig. 1.

calculate the actual cost of providing cardiac CT services, and to ensure that our tests are placed in an appropriate APC. Better valuation of the CT codes will also require that hospitals update their cardiac CT charges to ensure they are billing appropriately.

At present, numerous hospitals are charging CMS extraordinarily low amounts, while others are charging amounts that exceed $10,000. A review of CMS data shows over 500 sites in the U.S. that have estimated costs for coronary CTA (75574) of less than $100. Is your hospital one of these sites?

We are asking *all* U.S. SCCT members to reach out to their hospital finance departments to answer these two questions:

1. **How much does my hospital charge for cardiac CT exams?**
2. **How is the cost of cardiac CT exams determined in my hospital?**

Does your hospital calculate direct costs associated with CT testing or use the square-foot method for cost estimation? What is the CCR for the cost center that is used to submit cardiac CT claims?

We at SCCT already have this data. The point is that to affect change, you must know your own hospital numbers!

We also suggest that all U.S. members review the CT cost reports submitted by their hospital (hospitals provide this data annually by May 31). In doing so, you should understand if these are applicable to cardiac CT exams. (Spoiler: They are not! It is highly likely that your hospital does not have any accurate data on how much it costs to provide a cardiac CT or on what resources are used to provide this test. Most CT cost reports have no data on cardiac CT exams.)

While much of the above points are related to the technical component of cardiac CT, we also need to ensure the professional fee associated with cardiac CT is improved. Accordingly, we will be launching a campaign later this fall to educate our members on the RUC survey. (Stay tuned to SCCT emails and tweets to learn more!)

We sincerely thank all our members for their unprecedented support and commitment in advocating for cardiac CT. While we know the above details pertain to current struggles in the U.S., improving the adoption of cardiac CT is a global issue, and SCCT is working on identifying the challenges and advocacy needs that exist worldwide.

SCCT's key strength has always been its members — a diverse, highly-energetic, collaborative, and dedicated group of physicians, technologists, and scientists — who are passionate about the use of cardiac CT to improve patient outcomes. More than ever before, we all need to work together to advocate for our field. The time is now!

Disclosures

No related conflicts of interest.

Sincerely,
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