Submitter : **Dr. Howard Rosen** **Date: 11/05/2006**

Organization : **Dr. Howard Rosen**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

October 31, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

As a practicing interventional pain physician, I am disappointed at CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals, ASCs, and beneficiaries access will be harmed. While this may be good for some specialties, interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% in 2009 and after). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts. Using this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Based on this rationale, I suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I do want to let you know that my office overhead is $200 per hour. As much as I enjoy helping people if the present 4 year cut goes through I will retire from active practice is 3 years and just perform medical legal work. I hope this letter will assist in coming with appropriate conclusions that will help the elderly in the United States.

Sincerely,

Howard Rosen, M.D.
Sample Comment Letter for Physicians to Customize

Submitter : **Mr. Jerry Ford** **Date: 11/06/2006**

Organization : **Memorial Endoscopy Center, LP**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

. To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 62% is simply not adequate.

. ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list.

. ASCs should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments.

. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

Interim Relative Value Units

Interim Relative Value Units

Docket Number: CMS-1321-FC - Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calenda Year 2007 and other Changes to Payment Under Part B

Submitter : **Dr. Jocelyn Bush** **Date: 11/06/2006**

Organization : **Pain Specialists of Greater Chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attached letter

Submitter : **Dr. Bijan Niaki** **Date: 11/06/2006**

Organization : **Taunton Regional Pain Medicine Center**

Category : **Physician**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

November 6,2006
Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

As a practicing interventional pain physician, I am disappointed at CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals, ASCs, and beneficiaries access will be harmed. While this may be good for some specialties, interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% in 2009 and after). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts. Using this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Based on this rationale, I suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I hope this letter will assist in coming with appropriate conclusions that will help the elderly in the United States.

Sincerely,

Bijan N. Niaki, M.D.
Taunton Regional pain medicine center

Submitter : **Ms. Mary Sierra** **Date: 11/06/2006**

Organization : **Center For Advanced Eye Surgery**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

We are a free standing eye surgery center. Approximately 50% of our patient population is medicare. The majority of procedures scheduled at our facility are cataract extraction with IOL implant. We also schedule oculoplastic, glaucoma and strabismus surgical cases. ASC's should be able to furnish and receive facility reimbursement for any and all procedures that are performed in HOPD's. With rising inflation, costs of consumables, increasing energy costs, the proposed payment of 62% of HOPD rate is not acceptable and does not reflect a realistic differential of the costs incurred by hospitals and ASC's in providing the same services. Whatever percentage is eventually adopted by CMS should be applied uniformly to all ASC services regardless of specialty. Under current law ASCs are also not provided an annual cost of living adjusment whereas HOPD's will receive this on a regular basis. We in the ASC industry have the same issues to deal with in regards to rising costs and maintaining a budget that is being trimmed in every way possible, so we too should receive this annual cost-of-living update. The ASC industry has worked hard to institute efficiency, cut wastefull spending, train staff to work more efficiently etc. We should not be penalized for this efficiency. At the same time the ASC industry has established a safe environment and one that promotes the utmost in quality care to the patient.

Submitter : **Dr. William Hauter** **Date: 11/06/2006**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly disagree with the proposed change in medicare cuts to anesthesiologists. As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties.
The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses.
CMS should gather new overhead expense data to replace the decade-old data currently being used.
ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.
CMS must address the issue of anesthesia work undervaluation or our nation s most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine.

Submitter : **Date: 11/06/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

November 6, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

As a practicing interventional pain physician, I am disappointed at CMS s proposed rule for interventional procedure payments. This rule will create significant inequities between hospitals, physicians and beneficiaries access will be harmed. While this may be good for some specialties, interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% in 2009 and after). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts. Using this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Based on this rationale, I suggest that the proposal be reversed and a means be established where physician office based procedures are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated. Interventional pain procedures provide value to the patient by avoiding ER visits, hospitalizations, unnecessary surgery, fall prevention and allow patients to avoid medication escalation.

I hope this letter will assist in coming with appropriate conclusions that will help the elderly in the United States.

Sincerely,

Scott Stoney, MD MBA
California Medical Association member
American Medical Association member

CMS-1321-FC-8

Submitter : **Dr. Ira Goodman** **Date: 11/07/2006**

Organization : **Pain Specialists of Greater Chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see letter please

CMS-1321-FC-8-Attach-1.DOC

CMS-1321-FC-8-Attach-2.DOC

Sample Comment Letter for Physicians to Customize

October 31, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing you as a long practicing interventional pain management physician as well as a board member of the Illinois Society of Interventional Pain Physicians. I am very disappointed at CMS's proposed rule for ASC payments. This rule will create significant inequities between hospitals and ASCs ultimately resulting in reduced access to appropriate and effective treatments of pain for Medicare beneficiaries. The reductions are drastic and will be approximately 20% in 2008 and approximately 30% in 2009 and the years following. The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers.

CMS should also be aware that in general, the top-down methodology or bottom-up methodology used by Medicare is the primary driver for other payers. In other words, payers will use Medicare's rationale to lower their reimbursement levels. By incorporating this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Therefore, I suggest that the proposal be reversed. I also recommend that a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this goal. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

It is my sincere hope that you take this issue seriously. The incidence of chronic pain in the elderly is well documented. Restricting their access to minimally invasive, safe, effective, pain management procedures will have devastating effects and would be the ultimate outcome of the proposed rule.

Sincerely,

(Your Name)

Submitter : **Dr. John Marshall** **Date: 11/07/2006**

Organization : **Associated Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am very much opposed to the proposed reductions in the Medicare Physician Fee Schedule for 2007 and beyond. Medicare currently reimburses me less per hour than I pay my plumber! With further cuts, I will start reducing the number of Medicare patients in my practice. Thank you for your time.

Interim Relative Value Units

Interim Relative Value Units

I am very much opposed to the proposed reductions in the Medicare Physician Fee Schedule for 2007 and beyond. Medicare currently reimburses me less per hour than I pay my plumber! With further cuts, I will start reducing the number of Medicare patients in my practice. Thank you for your time.

Submitter : **Dr. jeffrey Ketcham** **Date: 11/13/2006**

Organization : **Associated Anesthesiologists,S.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Representatives and Senators:
It is inconceivable that the proposed change and negetive adjustment is not addressed at this point in time. By the sheer volume of comments, it should be clear that the SGR is a flawed formula and plan.
One looks to our government for fair and equitable treatment. This is clearly not the case. Please rectify the current near term crisis for 2007, and please develop a new system for adjustment of payment in services in a population increasing in both size and medical complexity. Thank you for your time.
Jeff K. Ketcham,M.D.

CMS-1321-FC-11

Submitter : Amy brown **Date:** 11/18/2006

Organization : Amy brown

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

It is disturbing to me that physician owned physical therapy practices have not yet been limited by our legislative bodies. Myself, and many PT's in private practice are being put out of business by self-referring physicians. The power of choice is limited to patients who are attended to by these physicians. When exercising thier right to choose a physical therapist and go outside of the MD owned practice, patient's paperwork is being refused by these same physicians. The patients are forced back into the MD's practice, because the MD's refuse to sign paperwork allowing insurance to be billed outside of their own practices. This does not seem ethical to me. What can we do as a profession to stop self referring MD's? Amy Brown, LPTA, and manager for Oregon Healthsouth- Physical Therapy.

Submitter : Mr. Craig Kennedy **Date:** 11/22/2006

Organization : National Association of Community Health Centers

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Plcasc scc attachmcnt.

CMS-1321-FC-12-Attach-1.DOC

November 22, 2006

BY ELECTRONIC MAIL
http://www.cms.hhs.gov/eRulemaking

U. S. Department of Health and Human Services
Att: CMS-1321-FC
P.O. Box 8015
Baltimore, MD 21244-8015

Re: CMS-1321-FC
Final Rule on Medicare Program: Diabetes Outpatient Self-Management Training Services (DSMT) and Medical Nutrition Therapy (MNT)

RINs 0938-AO24 and 0938-AO11
71 Fed. Reg.48982, et seq. (August 22, 2006).

Dear Sir/Madam:

The National Association of Community Health Centers ("NACHC") appreciates the opportunity to submit comments regarding the final rule issued by the Centers for Medicare and Medicaid Services (CMS) on implementing the payment provisions of the Deficit Reduction Act of 2005 that relate to the furnishing of Diabetes Self-Management Training Services (DSMT) and Medical Nutrition Therapy (MNT) by FQHCs; section 5114 of the Deficit Reduction Act of 2005 ("DRA") (Pub. L.109-171). The addition of DSMT/MNT services to the list of Medicare covered billable visits is an appropriate and positive change to the Medicare Federally Qualified Health Center (FQHC) benefit. NACHC strongly supports the change and welcomes this opportunity to comment on the final rule.

Background

NACHC is a membership organization that represents Federally Qualified Health Centers nationally. At present, more than 1,000 FQHCs with more than 5,000 sites serve approximately 15 million patients across the country. The vast majority of these patients are impoverished individuals living in medically underserved areas. More than one million of these FQHC patients are Medicare recipients. Due to the limited number of covered billable services under the Medicare FQHC reimbursement formula, many FQHCs provide care to their communities without adequate reimbursement.

DSMT/MNT Services as Billable FQHC Visits When Provided by a Qualified Provider of Such Services

As CMS states in the preamble to this final rule, prior to the passage of Section 5114 of the DRA of 2005, CMS policy allowed FQHCs to treat the furnishing of DSMT or MNT services by

FQHCs as allowable FQHC costs. However CMS only allowed such services to be billable visits if they were provided by one of five FQHC providers: physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers. As CMS states accurately in the preamble to its proposed rule, Congress amended the relevant provision of the Medicare statute in the DRA of 2005 to make clear that such services offered by FQHCs must be treated as billable visits. CMS notes in its preamble that Congress made this statutory change to assure that coverage and adequate access to these services are available in the FQHC setting. NACHC applauds and strongly supports CMS' recognition of Congressional intent behind this statutory change and believes the new rule will result in FQHCs being better able to provide these important services to their diabetic patients.

Payment to FQHCs for Group Visits for DSMT/MNT Services

NACHC believes it is important that CMS clarifies in its final rule that payment will be made to an FQHC when it delivers DSMT services in a **group** setting. We note that CMS rule 42 C.F.R. § 410.141(c) provides that Medicare Part B covers initial DSMT training and that, as a general rule "9 hours of the training are furnished in a group setting consisting of 2 to 20 individuals who need not all be Medicare beneficiaries." As an exception to the rule, the regulation provides that Medicare covers training on an individual basis when no group session is available within 2 months of the date the training is ordered or when the beneficiary has special needs that will hinder effective participation in a group training session" Section 410.141(c) (1) (ii)

NACHC believes that when an FQHC provides DSMT training to a group of patients per the above regulation, the FQHC must be allowed to bill one visit for each of the individuals in that group, since in such a situation the DSMT trainer engages in a face-to-face encounter with each patient. As an example, if 10 individual patients were in such a group, the center would bill 10 individual visits. While CMS may view such a billing approach as a windfall for the center, such is not the case. Under FQHC's reasonable cost reimbursement formula these additional visits will result in a reduction in the centers per visit rate. We recognize that CMS may be inclined to allow the health center only one billable visit rather than multiple visits. We note, however, that such an approach is directly contrary to Medicare's FQHC reasonable cost methodology which reimburses on a per visit (face-to-face encounter) basis. There certainly are many instances in which health centers are unable to bill for services they deliver (such as various screenings) because these services do not require a face-to-face encounter. It would be inequitable and, likely, contrary to law, for CMS to pick and choose when it will apply the face-to-face encounter requirement as the basis for a billable visit.

NACHC is compelled to address an additional issue related to payments for DSMT group visits, and that is the concern that CMS may determine that DSMT services provided by an FQHC in a group setting do not qualify as a billable visit but only as an allowable cost. Such a conclusion by CMS would directly contradict and undercut the specific requirements and purpose of Section 5114 of the DRA, which, as CMS has acknowledged, is to provide greater access to these services to Medicare patients who require them. While such a construction by CMS would still allow such services to be treated as allowable cost, it would not result in any payment to the majority of health centers whose current per visit reimbursement is already limited under CMS's current FQHC per visit "cap." In short, NACHC maintains that should CMS determine that a

DSMT group training session (be it initial or follow-up training) by an FQHC does not qualify as a billable visit, such a conclusion would negate the clear effect and intent of Section 5114 of the DRA and would violate the Medicare FQHC cost based reimbursement principle.

DSMT/MNT Certification

The proposed rule allows FQHCs to bill for DSMT/MNT services when those services are provided by qualified providers. The language reads "FQHCs that are certified providers of DSMT and MNT services can receive per visit payments for covered services furnished by registered dieticians or nutrition professionals." 71 Fed. Reg. at 48999. The rule does not clearly state whether the entity (the health center) must be a certified DSMT/MNT provider or whether the individual provider must be certified. We request that CMS clarify this issue, that is, must the FQHC entity be certified or must the health center employee or contractor be certified or must they both be certified?

This statutory and regulatory change to the FQHC Medicare benefit is an important one for health centers and their patients in that it will allow health centers to more effectively serve their patients and without being financially penalized for doing so. Thank you for the opportunity to further illuminate the regulatory change.

Respectfully submitted,

Craig Kennedy
Director of Federal Affairs
National Association of Community Health Centers

Submitter : **Dr. Todd Koppel** **Date: 11/26/2006**

Organization : **Garden State Pain Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my alarm at CMS s proposed rule for ambulatory surgery centers payment system. This rule will create significant inequities between hospitals, ASCs, and ultimately will harm beneficiary access. At these reduced reimbursement rates, physicians will not be adequately reimbursed for the services they provide to their Medicare patients and consequently, because all payers follow Medicare, this reduction in ASC reimbursements will affect not only patient access for Medicare patients but all interventional pain management patients.

The bottom line is that these rules will significantly affect my practice. I am having my practice administrators go through the numbers and let me know if it is any longer viable for me to treat medicare patients These proposed rules my force me to give up seeing medicare patients once and for all. I don t know how you think that when all other fields increase their fees, and all doctors practice fees (malpractice, office expenses, staff salaries) increase, that it is appropriate to lower our fee schedule.

I ask that CMS reverse the proposal. If no realistic proposal can be achieved at this time, Congress should repeal the previous mandate and leave the system alone as it is now, with inflation adjustments immediately reinstated. I thank you for your consideration.

Submitter : **Ms. Pam Michael** **Date: 12/08/2006**

Organization : **American Dietetic Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

The American Dietetic Association recommends CMS should establish the medical nutrition therapy (MNT) work RVUs for initial and follow-up MNT at the same level, e.g. 2007 RVU = 0.45 for 97802, 97803, and G0270. See details in the attached word document.

CMS-1321-FC-14-Attach-1.PDF

American Dietetic Association
Your link to nutrition and health.℠

120 South Riverside Plaza, Suite 2000
Chicago, IL 60606-6995
800/877-1600
www.eatright.org

Policy Initiatives and Advocacy
1120 Connecticut Avenue, Suite 480
Washington, DC 20036-3989
202/775-8277 FAX 202/775-8284

December 8, 2006

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1321-FC
P.O. Box 8014
Baltimore, MD 21244-8014

Re: CMS-1321-FC - Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B

The American Dietetic Association (ADA) is submitting comments on CMS-1321-FC: "Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B" published in the November 1, 2006 Federal Register. The ADA represents nearly 65,000 food and nutrition professionals, including registered dietitians (RDs) who are eligible to provide medical nutrition therapy (MNT) under Medicare Part B.

Medical Nutrition Therapy Work RVUs for Follow-up MNT
ADA acknowledges CMS' decision to establish work RVUs for medical nutrition therapy (MNT) codes 97802, 97803, 97804 and HCPCS codes G0270 and G0271. Creating work RVUs is the fair and equitable action to take for MNT-covered services provided by registered dietitians (RDs).

We strongly recommend the agency reconsider its decision to lower the work value for follow-up MNT (97803 and HCPCS code G0270). CMS already established precedent in its earlier rules where the follow up MNT RVU is the same as initial MNT. When RDs perform MNT services, the visit includes completion of a nutrition assessment, determination of a nutrition diagnosis, implementation of the nutrition intervention, and completion of nutrition

monitoring and evaluation. Even though these four steps are completed by RDs in follow-up MNT services, generally the follow-up MNT visits involves a shorter visit with the beneficiary, which reflects less units of the code resulting in lower Medicare payments.

In other words, CMS was right in the 2002 Final Rule[1], in noting "...the payments for CPT codes 97802 and 97803...should have the same values. The essential difference between an initial and follow up medical nutrition therapy service is the time spent performing the service. Initial visits will be longer than follow-up visits and will likely involve Medicare payment for more increments of service..."

Recommendation:
CMS should establish the MNT work RVUs for initial and follow-up MNT at the same level, e.g. 2007 RVU = 0.45 for 97802, 97803, and G0270.

Collaboration with AMA and CMS
ADA's Coding and Coverage Committee will consider CMS' comments that "ADA utilize the established RUC or HCPAC processes to further assess valuation of their [MNT] services." In developing our next steps to address MNT code RVU anomalies, we will continue communication with CMS so you are apprised of our ongoing code efforts.

In closing, ADA offers to assist CMS in educating physicians of the MNT provisions. Additionally, we would be happy to discuss in more detail the recommendations provided herein, should CMS require further information.

Respectively submitted,
Pam Michael, MBA, RD
American Dietetic Association
Director, Nutrition Services Coverage Team
312-899-4747
email: pmichael@eatright.org

[1] Centers for Medicare & Medicaid Services; 42 CFR Parts 405, 410, 411, 414, and 415; [CMS-1169-FC] Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002.

Submitter : **Date: 12/13/2006**

Organization : **Socity of Thoracic Surgeons**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Interim Relative Value Units

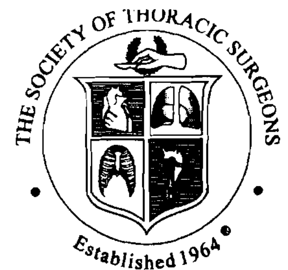
Interim Relative Value Units

Please See Attachement regarding STS Comments on the interm values for the atrial tissue ablation (Maze) procedures.

CMS-1321-FC-15-Attach-1.DOC

THE SOCIETY OF THORACIC SURGEONS

633 N. SAINT CLAIR STREET
SUITE 2320
CHICAGO, IL 60611
PHONE: 312-202-5800
FAX: 312-202-5801



December 13, 2006

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1321-FC
P.O. Box 8014
Baltimore, MD 21244-8014
http://www.cms.hhs.gov/eRulemaking

File Code CMS-1321-FC
Comments on "Interim Relative Value Units"

The Society of Thoracic Surgeons (STS) and the American Association for Thoracic Surgery (AATS) would like to thank CMS for accepting the RUC recommendations for the cardiothoracic procedures for the 5-year review.

The STS/AATS would also like to comment on the interim values published in the Nov 1, 2006 Final Rule for the new open atrial tissue ablation (Maze) codes (33254, 33255, and 33256). The STS/AATS agrees with the recommended values for the new codes. However we disagree with the CPT guidelines recommending use of the unlisted code 33999 to report an open Maze with another cardiac procedure. In addition to the guideline CPT has also developed a parenthetical note mirrored by the Medicare National Correct Coding (NCCI) Edits that bundles the new Maze codes into other cardiac procedures.

These codes were brought forward by the STS and AATS in good faith to replace code 33253 (now deleted) for the new, modified procedures that we believed involve less physician time and work.

The STS/AATS is concerned that implementation of these coding edits and the directive to use the unlisted procedure code 33999 for all instances where these codes are employed in a multiple procedure setting will unfairly burden cardiothoracic surgeons.

In the development of these new codes with the CPT Editorial Panel, there was considerable discussion about how these codes would be used and how often they would be used with other cardiac procedures. It was our original recommendation that this family of new codes should include "add-on" codes to assure proper valuation. In working with a CPT Editorial Panel facilitation committee, with CMS participation, it was determined that since these codes could be done as distinct "stand alone" procedures or in conjunction with other procedures that no add-on codes were necessary.

The original proposal was revised to reflect these recommendations, which were ratified by the full CPT Editorial Panel. These codes were brought to the RUC, and the RUC recommendation was that these codes (33254, 33255, and 33256) should be valued as

stand alone codes, but should not be allowed with other cardiac procedures. The RUC also recommended that additional ZZZ codes should be developed for use with other cardiac procedures. Based on the RUC recommendation the CPT editorial panel implemented coding edits prohibiting the use of the new codes with other cardiac procedures in closed session, without input from our specialty.

As a result of the RUC and CPT recommendations, The STS/AATS has submitted a CPT proposal to create ZZZ codes for these procedures in the 2008 CPT cycle. In the interim STS/AATS surgeons will bear the administrative burden of using the 33999 unlisted procedure code when the new atrial fibrillation procedures are used, which prior experience indicates will force individual review of claims and significant delays in payment.

The STS/AATS estimates that approximately 10,000 of these concurrent procedures will be performed in 2007 and would like to request CMS's help in easing the confusion and the burden on cardiothoracic surgeons for reporting these services for 2007. We have several recommendations as to how this can be accomplished.

The first recommendation would be for CMS to create new G codes for situations in which these new atrial fibrillation procedures are performed in conjunction with other cardiac procedures with interim values to facilitate prompt physician payment. These G codes would be defined as add-on codes, and therefore not subject to multiple procedure (51 modifier) reduction.

Our proposed values would be 50% of the CMS interim value (based on the RUC recommendations) for the related 090 global code until such time as RUC recommended values for the newly proposed ZZZ codes are available. In selecting these proposed values, we would emphasize that the RUC recommended values for the related 090 global codes are less than the median survey values. This reduction was in large part due to the presumption that the codes would be more frequently employed in the multiple procedure setting. The codes and values recommended are as follows:

G-X - Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure); performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)
RVW = 22.52 / 2 => 11.26

G-X1 - Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)
RVW = 27.52 / 2 => 13.76

G-X2 - Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass, performed at the time of other cardiac procedure(s) (List in addition to the code for the primary procedure)
RVW = 32.54 / 2 => 16.27

An alternative recommendation would be for CMS to eliminate the bundling edits on these codes and issue a National Coverage Determination indicating that payers should recognize the new codes 33254, 33254, and 33255 with the -51 modifier for 2007.

Another alternative would be for CMS to issue a National Coverage Determination that recognizes 33999 when used to report a Maze procedure in conjunction with another cardiac procedure for payment at 50% of the new codes 33254, 33255, or 33256.

We would appreciate your attention to this matter to facilitate appropriate guidance in the use of and payment for these codes in 2007.

Sincerely,

Peter K. Smith, MD
Chair, STS/AATS Nomenclature & Coding Workforce

Submitter : **Dr. Bonni Hazelton** **Date: 12/14/2006**

Organization : **BioCellutions**

Category : **Laboratory Industry**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

The implementation of the new PE RVUs for codes 88184 and 88185, as I understand, will be implemented at 25% per year for the next four years. Our facility was elated when, in August of 2005, CMS agreed that the PE RVUs for these codes did not adequately value the equipment, qualifications and training of staff and the cost of reagents. The change in the coding structure (splitting 88180 TC into two separate codes) resulted in a decrease in reimbursement from 2004. The "first" antibody had an allowable in 2005 and 2006 of 4% and 3% respectively above the 2004 88180 code. The remaining antibody allowables for both years were approximately 51% below the 2004 value. This resulted in a substantial decrease in reimbursement.
The fact that the change based on the results of the August meeting would NOT take place for the 2006 year was difficult to handle for a very small flow cytometry laboratory like ours.
Flow cytometry has been hoping for relief from the financial burdens related to Medicare reimbursement since January 2005. Maximum allowable reimbursement for a 15 marker panel, not including the GPCI, was approximately $523 (2003), $647 (2004), $354 (2005), $350 (2006), $479 (2007 proposed transitional). The benefit of the agreed upon corrected PE RVUs, implemented over the four years,puts our 2007 reimbursement below 2003 reimbursement. Projecting to 2008, the same panel would have an allowable of $559 which is above 2003, but not yet at 2004 levels. Granted, though this is an improvement over reimbursement from 2005 and 2006 it is little comfort when the proposed PE RVUs agreed upon by both Medicare and the expert panel if fully implemented would provide us an allowable of approximately $810/15 marker panel.
I have been trying to understand the proposed PE RVUs for the two codes and have received a very helpful explanation from some local carrier (CIGNA) employees. I now understand the process and how the transitional PE RVUs are calculated.
I would like to plead to those decision makers to reconsider transitional PE RVUs for at least the codes 88184 and 88185. A different formula which might give this specialty some well earned relief.
Thank you for providing us with this comment period.
Respectfully submitted
Bonni J. Hazelton, PhD

Submitter : **James P. Schlicht** **Date: 12/15/2006**

Organization : **American Diabetes Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1321-FC-17-Attach-1.DOC

AMERICAN DIABETES ASSOCIATION COMMENTS ON
FINAL RULE CMS-1321-FC:
Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Under Part B

The American Diabetes Association is disappointed that the Final Rule CMS-1321-FC retains a provision which would modify 42 C.F.R. § 424.24(f) to require providers to certify the medical necessity of each individual blood glucose test as a condition of reimbursement under Part B. Blood glucose monitoring is a crucial element of quality diabetes care which should be easily accessible to all patients with diabetes. As written, this provision will burden skilled nursing facilities with an unnecessary and onerous administrative requirement, thus limiting their ability to provide clinically appropriate care to a particularly frail and vulnerable population.

Approximately 1 out of every 5 Medicare beneficiaries is affected by diabetes. Diabetes is a life threatening chronic illness which can lead to serious complications such as retinopathy, neuropathy, nephropathy, and cardiovascular disease. Residents of nursing facilities are especially vulnerable: 90% of nursing home residents with diabetes have evidence of coronary artery disease, stroke, and/or peripheral vascular disease[1].

Furthermore, studies have shown that blood glucose monitoring can help patients and their diabetes care team delay the progression of costly long-term complications, prevent them entirely, or even reverse the effect of some complications. Blood glucose monitoring is also crucial in fighting short-term complication such as hypoglycemia, particularly in patients using insulin to manage their diabetes.

[1] Resnick, Barbara. Diabetes Management: The Hidden Challenge of Managing Hyperglycemia in Long-Term Care Settings. Annals of Long Term Care, vol. 13 no. 8 (August 2005).

Before Final Rule CMS-1321-FC was implemented, a Part B provider could certify that series of services, such as multiple blood glucose tests performed over the course of a day, week, or month, was medically necessary and thus eligible for reimbursement. No recertification of continued need for blood glucose monitoring was required.

However, the revised version of §424.24(f) amends this more reasonable standard to require a separate order for each blood glucose test performed on skilled nursing facility residents with diabetes. While the Association appreciates the need to protect against fraud and ensure that patients are truly benefiting from the tests which are billed to Medicare, this approach creates an unreasonable administrative barrier to a key element of quality diabetes care. It is unlikely that a provider will have sufficient time to produce the required documentation, particularly for patients requiring multiple blood glucose tests each day in order to effectively manage their diabetes. This will result in fewer tests being ordered –perhaps the actual intent of the provision– thus jeopardizing the health of skilled nursing facility residents with diabetes.

The new rule also creates unnecessary confusion by creating a new and burdensome billing procedure for Part B providers, while allowing other providers to continue billing for multiple blood glucose tests under "standing orders." CMS provides no medical or clinical explanation as to why Part B providers must produce a separate medical necessity certification for each and every blood glucose test administered to a skilled nursing facility resident, while other providers do not. Nevertheless, the additional documentation requirements under the new rule are unreasonable and

unnecessary, regardless of how the test is being billed. The health of the patient, not the billing and reimbursement procedure, should be paramount.

The Association is especially disappointed that CMS would institute a rule which is so contrary to the spirit and intent of recent CMS initiatives promoting quality diabetes care. Blood glucose monitoring is an important preventive measure which could significantly reduce Medicare spending on diabetes. The Association urges CMS to reconsider its decision to implement this new reimbursement policy, which burdens Part B providers with unnecessary and clinically inappropriate documentation requirements and endangers the health of skilled nursing facility residents with diabetes.

Submitter : **Mr. Robert Blaser** **Date: 12/19/2006**

Organization : **Renal Physicians Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1321-FC-18-Attach-1.DOC

December 14, 2006

Leslie Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1321-FC and CMS-1317-F
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Part B (CMS-1321-FC and CMS-1317-F) Final Rule

Dear Ms. Norwalk:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

We are writing to express our vehement objections to the Agency's response to RPA's recommendations concerning the proposed rules for the Five-Year Review of Work Relative Value Units and the 2007 Medicare Fee Schedule. It is our belief that CMS' current disposition in this area is highly inequitable, will ruin the rank-order relationship between dialysis care and evaluation and management (E&M) services, and will thus prove to be extremely harmful to nephrology as a subspecialty and to the Medicare beneficiaries with kidney disease treated by nephrologists. Further, we believe that the rationale offered for rejecting RPA's recommendations is fallacious and without merit, since the reason that the CPT descriptors no longer correspond to the G-codes is because CMS itself unilaterally imposed a new payment system upon nephrology in 2004 over the stated objections of the kidney and organized medicine communities.

It is for these reasons that we urge CMS to provide an interim adjustment for calendar year 2007 that will revise the work relative value units for the inpatient and outpatient dialysis code families to reflect the recommendations provided in our previous correspondence.

This comment letter will address our specific concerns regarding the appropriateness of providing the E&M increase to dialysis care with regard to maintaining equity and relativity in the fee schedule and the merits of the rationale outlined by CMS in the Final Rule.

Applicability of E&M Work RVU Revisions to Dialysis Services

Equity and Relativity

As noted in RPA's comments on the Five-Year Review, we support CMS' agreement with the RUC's recommendation to incorporate the full increase for the E&M codes into the surgical global periods for each CPT code with a global period of 010 and 090. Accordingly, we expressed our belief that the outpatient and inpatient dialysis services that use E&M codes as "building blocks" or components of their valuation should have the full increases for the E&M codes incorporated into their values as well. The monthly dialysis family of services now indicated by a series of G-codes (G-0308 through G-0327) was developed based on an E&M building block methodology approved and implemented by then-HCFA; the inpatient service codes (CPT Codes 90935-90947) are reported to describe both hemodialysis and dialysis procedures other than hemodialysis with all E&M services related to the patient's renal disease on the day of the procedure.

RPA's comments proceeded to discuss revisions to the outpatient and inpatient dialysis codes in the context of equity and relativity. Regarding equity, we noted that in addition to the 10- and 90-day global surgical packages, the values published in the notice gave the appearance that the increases in the E&M services are being applied to the global maternity package as well (CPT code series 59400). Further, we pointed out that while the dialysis G-codes and inpatient dialysis codes are not E&M services per se, they are roughly akin to E&M services. RPA then expressed our belief that if the decision had been made to apply the building block E&M codes increases to global packages in other domains, to maintain equity and consistency, CMS should apply the increases to the inpatient and outpatient families of dialysis codes as well.

With regard to relativity, we offered the illustrative example that in 2004 the reimbursement for CPT code 90935 (hemodialysis, single evaluation) was roughly equivalent to a level three subsequent hospital visit (CPT code 99233), and if left unchanged the proposed 2007 values will result in a reimbursement level that would be roughly equivalent to a level two subsequent hospital visit (CPT code 99232).

The cumulative conclusion of all of these points is that it is not only highly inequitable but also beyond reason to provide the work RVU increases emanating from the E&M codes increases to certain bundled, "building-block based" service code packages, and then arbitrarily deny providing the same increases to similarly-developed service code packages. If the decision has been made by the CMS based on RUC recommendations to apply these increases to global service packages, it should be a matter of simple logical progression to apply them to all such packages.

Further, it seems that the Agency is abandoning the principles upon which the relative value scale is based. For CPT code 90935 to be revised downward in the relative value relationship from being roughly equivalent to a level three hospital visit in 2004 to a level two hospital visit by 2007 is astoundingly inappropriate and a threat to the viability of the subspecialty treating the most vulnerable patient sub-population in the Medicare program.

It is critical to note that RPA and nephrology as a subspecialty is not raising these issues in a vacuum—rather, RPA staff consulted with responsible CMS staff regarding the validity of our recommendations and were advised that there was reasonableness to our assertions that had to be

accounted for. The American Medical Association (AMA), and the American College of Physicians (ACP-the umbrella organization for internal medicine and the largest specialty society in the country) both advised the RPA of the legitimacy of our arguments, and both organizations submitted comments supporting our position. Also, Kidney Care Partners (KCP), a coalition of public and private organizations involved in the provision of dialysis care, provided comment to CMS calling for the E&M work RVU increases to be applied to inpatient and outpatient dialysis services. Thus, the AMA, the ACP, the KCP, and even CMS staff advised RPA that our position was reasonable and appropriate, yet the Agency chose to not even address the issues raised in our recommendations.

CMS' Response to RPA's Recommendations

In the final rule, CMS provided the following response to RPA's recommendations:

> *"Since the G-codes now used for these ESRD-related services have markedly different descriptors than the previously valued CPT codes, we are unable to determine at this time which levels of E&M visits are most appropriately associated with these G-codes. As explained in the CY 2004 PFS final rule, we established RVUs for these codes to equal the aggregate payments for the services provided under the CPT codes that had been previously recognized for these services. Because we based our payment of the G-codes on the aggregate payments for CPT codes 90918-90921, the specific CPT codes that are building blocks of this payment system cannot be directly correlated. We suggest that the specialty could request that the CPT panel consider revising the CPT codes for these ESRD-related services to mirror our current G-codes; these could then be reviewed by the RUC to determine the level of E&M services that are typically associated with each code."*

RPA believes this response is fallacious in several ways. First, the reason that the ESRD-related services have markedly different descriptors now is because ***CMS itself changed them***, over the stated objections of RPA, the balance of the renal community, and the AMA and ACP. As a result, not only did the nephrology community have an insufficiently vetted system imposed upon it in 2004, but the existence of the new system, established despite community-wide objections, is now being cited as the primary obstacle to what RPA, AMA, ACP and others have indicated is a fair and appropriate revaluation of the dialysis codes.

Second, the lack of a correlative relationship between the previous dialysis CPT code series (CPT codes 90918-90921) and the G-codes did not prevent the Agency from establishing values for the G-codes in 2004, and we believe that CMS should remain consistent and uniform in its chain of logic and thus have the monthly dialysis codes correspond to the sum of their E&M building blocks based on the mid-level adult G-code (G-0318) and extrapolated proportionately to other codes in the family, and to revise the inpatient dialysis code to reflect their E&M elements.

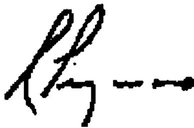
Our final area of concern relates to the CPT and RUC processes. The Agency's suggestion to pursue changes through CPT and RUC is certainly valid and an issue the RPA has begun to address. Accordingly, RPA has been meeting with nephrologists in various regions across the country to discuss a survey tool based on the AMA-RUC survey instrument. This is an effort to accurately determine the E&M code building blocks that correspond to the current physician

work involved in providing monthly dialysis care (and all of the other work performed in the dialysis unit that is part of the MCP), and to discuss other methods of physician work value assessment. However, the CMS response not only seems to insufficiently account for the lengthy timeframe involved in undertaking the CPT and RUC processes, but also ignores the impact of the changes in the final rule on the relativity of the codes under review. Between the use of the work adjuster to maintain budget neutrality for the E&M increases and the implementation of the revised practice expense methodology, nephrology will experience four years of RVU reductions of varying degrees between 2007 and 2010. RPA strongly believes that CMS must maintain the equity and relativity of these codes during this phase of code construction in order to facilitate the accuracy of future RUC efforts.

In light of these circumstances, we believe that it is only reasonable for CMS to provide an interim revision of the work RVUs for inpatient and outpatient dialysis codes as suggested in our comments on the Five-Year Review and the Fee Schedule proposed rule, as supported by the major stakeholders in the organized medicine and renal communities.

As always, we welcome the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation's ESRD patients, and we stand ready as a resource to CMS in its future endeavors. I also will make myself available to meet with you and your staff at any time to discuss the issues raised in this letter. Any questions or comments regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,



Robert Provenzano, M.D.
President

CC: The Honorable Arlen Specter
The Honorable Debbie Stabenow
The Honorable Sherrod Brown
The Honorable David Camp
The Honorable Nancy Johnson
The Honorable Carolyn Kilpatrick

Ira Burney, CMS
Herb Kuhn, CMS
Carolyn Mullen, CMS
Kenneth Simon, M.D., CMS
Barry Straube, M.D., CMS

Submitter : **Dr. David Rice** **Date: 12/21/2006**

Organization : **Assn. of Freestanding Radiation Oncology Centers**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1321-FC-19-Attach-1.DOC

AFROC
ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS
Our Voice in Washington

December 21, 2006

Leslie V. Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington DC 20201

Re: CMS-1321-FC; Revisions to Physician Fee Schedule for CY 2007

Dear Ms. Norwalk:

On behalf of the Association for Freestanding Radiation Oncology Centers (AFROC), I am writing to you regarding the final Physician Fee Schedule for CY 2007 (the "2007 PFS").

Preliminarily, we wish to thank CMS for its comprehensive analysis of AFROC's comments regarding the practice expense/hour (PE/hr) for radiation oncology, and its decision to increase the radiation oncology PE/hr based on the study conducted by Direct Research and submitted with AFROC's comments. We very much appreciate the work performed by CMS and by its contractor, the Lewin Group, on this issue.

We would appreciate clarification of one issue raised by the 2007 PFS, relating to Medicare payment and coding for stereotactic radiosurgery and radiotherapy. It is our understanding that there are three new CPT codes for stereotactic radiosurgery/radiotherapy that will become effective in January, 2007:

- CPT Code 77371 – Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of one session; multi-source Cobalt 60-based.

- CPT Code 77372 – Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of one session; linear accelerator based.

- CPT Code 77373 – Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed five fractions.

In addition, the CY 2007 PFS includes a number of "G" codes for robotic, image guided radiosurgery (G0339 and G0340), which are listed as carrier priced (Status Indicator "C").

We are concerned that the allowances for the new CPT codes established for use in CY 2007 (CPT codes 77371, 77372 and 77373), which will range from approximately $800 to approximately $1500 in CY 2007, are entirely inadequate to cover the costs of the services involved. For example, we are aware of one facility that provides cobalt-based SRS which cost over $5 million to construct and equip.

We are not aware of a significant number of facilities that provide stereotactic radiosurgery (either cobalt or linear accelerator-based) or stereotactic body radiation therapy on a freestanding basis. Because there have been no CPT codes available to report the enormous technical component costs involved, it is our understanding that most of the facilities that provide these services are hospital-based, and we believe it unlikely that there are a sufficient number of freestanding facilities in operation to ensure that the direct cost data underlying the interim final RVUs set forth in the Final Rule are accurate. Nor does that data appear to be available on the CMS website.

In addition, we believe that the cost of these services is quite dependent on circumstances that are particular to each facility. While the capital costs involved are substantially higher than the costs involved in the provision of conventional radiation therapy, the appropriate patient population is relatively small. Therefore, the cost per service is very dependent on relatively small variations in volume.

In light of the relative dearth of freestanding facilities that provide these services and the relative infrequency of the provision of these services at this time, we recommend that these services be carrier-priced, at least until a more robust data base can be established. Maintaining carrier-based status for these services would be consistent with the decision to allow carrier pricing of robotic, image-guided stereotactic radiotherapy and the well-reasoned decision to continue the carrier-priced status of proton beam radiotherapy, another radiation oncology service involving extraordinary facility costs and relatively few patients.

We appreciate your consideration of these comments and look forward to working with CMS in further refining the Medicare payment for radiation therapy technical component services over the coming years.

Sincerely yours,

Association of Freestanding Radiation Oncology Centers

David Rice, MD
President

cc: AFROC Board
Sheila Gell

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