Submitter : Dr. Carl Mele **Date:** 11/06/2006

Organization : Berks Center for Digestive Health

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachmcnt

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. John Nealon **Date:** 11/06/2006

Organization : American Medical Systems

Category : Private Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment. Thank you.

CMS-1506-P2-1139-Attach-1.DOC

#1139

AMS
Solutions for Life

10700 Bren Road West
Minnetonka, MN 55343 USA

Phone: 952-933-4666
Fax: 952-930-6157

November 6, 2006

Filed Electronically

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

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

Dear Administrator Norwalk:

American Medical Systems ("AMS") appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") Medicare ambulatory surgical center (ASC) payment system & CY 2008 payment rates (the "Proposed Rule").[1]

AMS is a leader in medical devices and procedures to treat urological and gynecological disorders such as erectile dysfunction ("ED"), urinary incontinence, and menorrhagia. Although not life-threatening, these disorders can greatly affect one's quality of life and social relationships. As such, AMS is keenly interested in the changes recommended in the Proposed Rule concerning payment rates for prosthetic urology and minimally invasive gynecologic procedures in an ASC setting. Our comments are intended to ensure that ASC payments for these services supports high quality care for Medicare patients.

Our recommendations are below:

- **ACS Rate-Setting:**

  We commend CMS for proposing to use the APC groupings and relative weights from the hospital outpatient prospective payment system (HOPPS) as the basis for calculating the payments for that same procedure code when performed in an ASC setting. However, given that the ASC conversion factor is proposed to be significantly less than the HOPPS conversion factor, we believe a better solution is to have CMS use a flat percentage payment of the APC rate, for a urology or gynecology procedure that uses an expense implantable/device, ensuring that access is maintained to services performed in an ASC.

- **ASC Packaging:**

  We agree that as a matter of sound payment policy, packaging of implants should be the same in ASCs and in Hospital Outpatient Departments (HOPDs). Historically, ASCs have struggled with the inconsistent carrier coverage policies for separately payable devices and implants. However, we are concerned that the proposed budget neutrality adjustment used to generate the ASC conversion factor will result in under payment for prosthetic urology services because of their significant implant costs.

  Therefore, to ensure adequate payment for urology and gynecology procedures in an ASC that involve the implantation of a costly device, AMS urges CMS to account for the device

[1] See 71 Fed. Reg. 49506 (August 23, 2006).

dependent portion of the APC payment separately, allowing them to be passed through to the ASCs at cost and applying the budget neutrality discount only to the non-device portion of the ASC payment.

- **ASC Phase-In:**

  AMS is extremely concerned that a phase-in period for those surgical procedures with a implantable device places those procedures at a severe disadvantage because they are no longer allowed to bill the DMEPOS system for the cost of the device that is not part of the phase-in, or for the cost of the device, separate from the cost of the procedure. Therefore, we would urge CMS to **NOT** phase in surgical procedures with expense implantable devices and instead have those surgical procedures be paid at the CY 2009 rate immediately in CY 2008. At a minimum, CMS needs to exempt prosthetic urology procedures from the phase-in, given that the proposed rates do not even cover the cost of the prosthetic urology implant.

- **ASC Conversion Factor:**

  We are concerned that CMS has included only the aggregated expenditures in the budget neutrality calculation from the ASC groupings andt has not included all the expenditures that were billed by ASCs in a given year to another fee schedule. For instance, part of the aggregated expenditures of procedures performed in an ASC is the implantable and other devices that were billed by ASCs to the DMEPOS fee schedule. These expenditures must be included in the budget neutrality calculation and in the determination of the CY 2008 ASC conversion factor.

  We urge CMS to work with the DMERCS to collect the data regarding reimbursements to ASCs for implantable devices and to include these dollars in the aggregated expenditures used to calculate the budget neutrality adjustment. We are concerned that this artificially low conversion factor of $39.688 will impede access to appropriate surgical procedures in an ASC for Medicare beneficiaries. Maintaining ASC access requires reasonable payment rates, and since current ASC rates are based upon 20-year old data and a 6-year freeze, a broad interpretation of budget neutrality is necessary to establish appropriate rates and allow Medicare and its beneficiaries to take advantage of the myriad benefits of ASCs.

  We also share the concerns expressed by the Medicare Payment Advisory Committee (MedPAC)[1] that CMS's charge data from 1986 are "probably no longer consistent with ASCs' actual costs." MedPAC points out: "[b]ecause CMS has not collected recent ASC cost data, we are not able to estimate ASCs' costs or determine which surgical setting has the lowest costs. Thus, the Commission is unable to judge whether an ASC conversion factor that equals 62 percent of the OPPS conversion factor is appropriate." We agree that it is inappropriate to establish an ASC conversion factor without a true picture of ASC costs. CMS should not establish a new payment system until it has reliable data that ensures ASCs are adequately compensated for providing quality care to Medicare beneficiaries.

[1]See://www.medpac.gov/publications/other_reports/101006_ASC_%20comment_AW.pdf?CFID=9299012&CFTOKEN=78096660.

***

Again, AMS thanks CMS for the opportunity to provide comments on the proposed Medicare Physician Fee Schedule for 2006. If you have any questions regarding these comments, or if you would like additional information, please contact Gary Goetzke at 952-930-6155 or Jill Rathbun at 703-486-4200.

Sincerely,

John Nealon
John Nealon
Senior Vice President
Business Development

Gary Goetzke
Gary Goetzke
Senior Director
Health Care Affairs

cc: Dr. John Mulcahy, Chairman, CAPU
David Nexon, Senior Vice President, AdvaMed

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

Organization : Advanced Pain Management

Category : Individual

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 concerned citizen, 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. While this may be good for some specialties, it is clear that interventional pain management will suffer substantially - approximately 20% in 2008 and approximately 30% in 2009 and thereafter. 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.

Given the impact this proposed rule would have on interventional pain physicians practicing in ASCs and their ability to provide services to Medicare patients, I ask that CMS reverse the proposal and that a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. 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.

On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,

Crystal Kennon

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

Organization : **Peekskill/ Cortlandt Dialysis Center**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

GENERAL

GENERAL

After speaking to all our patients and staff, this was the general census:

The patients think that the ambulatory surgery center would be nice mainly because they do not like to have to go to the hospital.However, they do not take into consideration that there is no emergency precautionaries as opposed to going to have VA work done in a hospital setting, where they would be better prepared and equiped for any complications that may arise. That is the main concern of the staff spoken to, who, as a whole, don't think that it would be a good idea.

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

Organization : **Advanced Pain Management**

Category : **Individual**

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
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On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,

Vishal Lal

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

Organization : **Advanced Pain Management**

Category : **Individual**

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
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200 Independence Avenue, SW
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Given the impact this proposed rule would have on interventional pain physicians practicing in ASCs and their ability to provide services to Medicare patients, I ask that CMS reverse the proposal and that a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. 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.

On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,

Jullia Lonergan

Submitter : Mrs. Rebecca Carver **Date:** 11/06/2006

Organization : USPI Memorial Hermann Surgery Center Southwest

Category : Nurse

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

62 % conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model.

ASC Inflation

ASC Inflation

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. 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.

ASC Office-Based Procedures

ASC Office-Based Procedures

We support CMS s proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.

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ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the 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 and follow the state regulations for overnight stays.

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

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ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

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ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

ASC Updates

ASC Updates

We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

ASC Wage Index

ASC Wage Index

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Submitter :

Date: 11/06/2006

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-1145-Attach-1.DOC

#1145

BAPTIST-PHYSICIANS'
SURGERY CENTER

November 6, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare & 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

Dear Administrator Norwalk:

I am writing in response to the proposed changes to the Medicare payment system for ASCs. While I commend the CMS for their efforts in developing a new system, I feel that the current proposal is simply not adequate for the ambulatory surgery center industry.

After an initial review, it appears that the proposed reimbursement of 62% of HOPD rates may not be sufficient to sustain a viable ASC industry. Instead, the CMS should more broadly interpret the budget neutrality provision enacted by Congress to assure Medicare beneficiaries' access to ASCs.

In addition, ASC rates should be updated based upon the same system and the same relative weights used for HOPDs, including the hospital market basket, because this more appropriately reflects inflation in providing surgical services than the consumer price index.

I believe that aligning the payment systems for ASCs and hospital outpatient departments should improve the transparency of cost and quality data used to evaluate surgical services for Medicare beneficiaries.

Thank you for taking a minute to review these comments.

Sincerely,

Robert Ramey
Administrator

Baptist-Physicians' Surgery Center · 1720 Nicholasville Rd Suite 101
Lexington Kentucky 40503 · 859-260-7000

Submitter : Dr. David Hildreth **Date:** 11/06/2006

Organization : Dr. David Hildreth

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

ASC LIST REFORM

Submitter : Ms. Jeffrey Stockard **Date:** 11/06/2006

Organization : Community Care, Inc.

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Dr. Ricardo Vallejo** **Date: 11/06/2006**

Organization : **Millennium Pain Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

11/6/2006

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 an interventional pain physician, I am disappointed at CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals, ASCs, and at the end patients 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 variety of solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really reasonable 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 reasoning, I suggest that the proposal be reversed and a method be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. I 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 patients suffering from chronic pain in the United States.

Sincerely,

Ricardo Vallejo, M.D., PhD.

Submitter : Dr. Thomas Larkin **Date:** 11/06/2006

Organization : Pain Management Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I believe that CMS should establish a fair and reasonable conversion factor that appropriately reflects the costs associated with an ASC for interventional techniques. The proposed rules do not achieve this.

Submitter : **Mrs. Stephanie Toungett** **Date: 11/06/2006**

Organization : **Central Illinois Neuro Health Sciences**

Category : **Nursing Aide**

Issue Areas/Comments

GENERAL

GENERAL

11/6/2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
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Washington, DC 20201

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

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Given the impact this proposed rule would have on interventional pain physicians practicing in ASCs and their ability to provide services to Medicare patients, I ask that CMS reverse the proposal and that a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. 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.

On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,

Stephanie Toungett

Submitter : Mrs. Donna Danley **Date:** 11/06/2006

Organization : United Surigcal Partners International

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

A 62 % conversion factor is unacceptable and often does not cover the cost of the procedure potentially forcing facilities not to perform these procedures forcing the Medicare patient back into the more expensive hospital setting. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model of a 73% conversion factor.

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ASC Office-Based Procedures

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Submitter : **Mrs. Nancy Jarnigan** **Date: 11/06/2006**

Organization : **Millennium Pain Center**

Category : **Nursing Aide**

Issue Areas/Comments

GENERAL

GENERAL

11/06/2006

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
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On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,

Nancy Jarnigan

Submitter : Dr. James Esch **Date:** 11/06/2006

Organization : Tri-City Othopaedics

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

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ASC Updates

ASC Updates

We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

Submitter : **Ms. Marcia Adler** **Date: 11/06/2006**

Organization : **Oregon Eye Surgery Center, Inc.**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Packaging

ASC Packaging

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-1506-P

Re: ASC Packaging

Dear Dr. McClellan:

Thank you for the opportunity to comment on the proposed changes to ASC payment policies. On behalf of the Oregon Eye Surgery Center, Inc., I wish to comment specifically on the proposal to cease making separate payment for implantable prosthetic devices and implantable DME inserted surgically at an ASC.

In the course of performing ophthalmic surgery, there are times that implantable devices and donor tissue are necessary to save patients' vision. You have acknowledged the need to reimburse for Cornea Tissue, but similar needs also arise for Scleral Tissue and Amniotic Membrane, and these implant surgeries are appropriate for the ASC setting.

In addition, our surgeons have found the use of a Capsular Tension Ring during some cases of cataract surgery to be critical to supporting a posterior chamber intraocular lens, when there is a loss of stability in the zonular structures. When the Capsular Tension Ring implant is inserted following capsulorhexis, capsular integrity can be maintained or re-established prior to inserting the intraocular lens.

Glaucoma implants, such as aqueous shunts, provide a therapeutic alternative when anti-glaucoma medications, laser trabeculoplasty, trabeculectomy and other surgical procedures have failed. Aqueous shunts have saved many eyes, and again, are very appropriate procedures for an ASC setting.

In conclusion, we strongly encourage you to maintain separate reimbursements, at cost, for prosthetic implants and implantable DME that are inserted during a procedure. We know from experience that the bundled costs that comprise your reimbursement strategy do not allow for the less common implants that are nevertheless surgically necessary.

We, like you, are concerned for the Medicare beneficiaries who are affected by the impact of these rules on their access to vision care.

Respectfully submitted,

Marcia Adler, Controller
Oregon Eye Surgery Center, Inc.

CMS-1506-P2-1154-Attach-1.DOC

#1154

November 6, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
Baltimore, MD 21244

Re: CMS-1506-P **ASC Packaging**

Dear Dr. McClellan:

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We, like you, and concerned for the Medicare beneficiaries who are affected by the impact of these rules on their access to vision care.

Respectfully submitted,

Marcia Adler, Controller
Oregon Eye Surgery Center, Inc.
1550 Oak Street
Eugene, OR 97401

Submitter : Dr. Bruce Hochman **Date:** 11/06/2006

Organization : Dr. Bruce Hochman

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

A 62 % conversion factor is unacceptable and often does not cover the cost of the procedure potentially forcing facilities not to perform these procedures forcing the Medicare patient back into the more expensive hospital setting. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that.is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model of a 73% conversion factor.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs. These facilities exist in the same communities and often in partnership with the community hospital. 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 aligning the payment policies to the greatest extent permitted under the law will maximize the benefits to the taxpayer and the Medicare consumer.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

Submitter : Dr. James Helgager **Date:** 11/06/2006

Organization : Tri-City Orthopaedics

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

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Submitter : Dr. Thomas Shima **Date:** 11/06/2006

Organization : Dr. Thomas Shima

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

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Submitter : Dr. Marion Lee **Date:** 11/06/2006

Organization : Dr. Marion Lee

Category : Physician

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

I opppose the reduction in payment schedules for ASC based pain procedures.

Submitter : Ms. gwen schmitz **Date:** 11/06/2006

Organization : Healthsouth Surgery Center of Castro Valley

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

An attachment re: CMS rule changes

CMS-1506-P2-1159-Attach-1.TXT

#1159

November 6, 2006

Leslie V. Norwalk, Esq. Acting Administrator
Center for Medicare & Medicaid Services
Dept of Health and Human Services

Dear Administrator Norwalk,

I'm a Surgery Center Administrator, and have great concerns re: proposed CMS Payment System and ASC List Reform.
62% reimbursement is not adequate to recover our costs and allow Surgery Centers to remain a cost effective alternative for patients and CMS.
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.
The same relative value weights should be used in ASC's and HOPD's.
Aligning the payment systems for ASC's and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries.
I believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent possible under the law.

Thank you for your time and attention,

Gwen Schmitz, Administrator
Healthsouth Surgery Center of Castro Valley
20998 Redwood Road
Castro Valley, California 94546

Submitter : Mrs. Marion Wilson **Date:** 11/06/2006

Organization : DaVita Dialysis

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

An Ambulatory Surgical Center Payment System is long overdue - it is more expedient for the patient, and more cost-effective than the cumbersome system we operate under currently.

Submitter : Dr. Ralph Hesler **Date:** 11/06/2006

Organization : Private Practice

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

A 62 % conversion factor is unacceptable and often does not cover the cost of the procedure potentially forcing facilities not to perform these procedures forcing the Medicare patient back into the more expensive hospital setting. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model of a 73% conversion factor.

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the 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 and follow the state regulations for overnight stays.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

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ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

Submitter : Mrs. Kathie Stewart **Date:** 11/06/2006

Organization : Cascade Spine Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attachment

CMS-1506-P2-1162-Attach-1.DOC

ASC's provide Medicare beneficiaries and physicians direct control over choice of surgical settings and surgical practices. In the ASC setting, physicians are able to schedule procedures more conveniently and with more flexibility to accommodate the Medicare beneficiary's needs. In the ASC setting, physicians are able to assemble teams of specially-trained and highly skilled staff and are able to ensure the equipment and supplies being used are best suited to their technique. The ASC facility and staff are designed and tailored to their specialty. Physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Cascade Spine Center specializes in Interventional Pain Management. The Center was designed and constructed with clinical footage and clinical personnel as the focus for the delivery of healthcare. All of the staff RN's, Radiology Technicians and other clinical staff specialize in Pain Management. They are dedicated to the needs, processes, protocols, clinical standards, and overall commitment to provide quality care to Medicare beneficiaries and all others who use the facility.

The Medicare Modernization Act of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. There are three (3) basic principles to focus on:

- maximizing the alignment of the ASC and HOPD payment systems, eliminating distortions between the payment systems that could inappropriately influence site of service selection.
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Aligning the payment systems for ASCs and HOPDs will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. However, there are concerns that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for HOPDs were not extended to the ASCs. The inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payments systems is appropriate. Following is an overview of the major areas where further refinement is warranted.

- **Procedure List:** ASCs should also be eligible for payment for any service that is not included on the inpatient list so there is complete alignment with HOPDs. The CMS proposal limits the physician's ability to determine appropriate site of service for a procedure and excludes many surgical procedures appropriate for the ASC setting.
- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.
- **Non-application of HOPD policies to the ASC:** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.
- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. Depending on the services that are being offered, Medicare beneficiaries may experience changes in site of service to

HOPDs, thus increasing expenditures for the government and the beneficiary, or you will find a decrease in the proportion of Medicare patients that physicians will be seeing in the ASC if payment rates are too low. In the later case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

Considerations

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs and HOPDs.
- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD. The recommendation that was made from the ASCs was between 70%-75%.
- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.
- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is loosing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

- 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.

CMS needs to take the appropriate steps to ensure that Medicare beneficiaries and their doctors can make the decisions for the appropriate procedures and the site of care. CMS also needs to ensure that monies spent on beneficiaries care is aligned with high quality care, cost savings, transparency and the Medicare beneficiaries rights to choice of site and choice of how their dollars are spent.

Submitter : **Dr. Wayne Fleischhacker** **Date: 11/06/2006**

Organization : **Union Anesthesia Associates**

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

Sincerely,

Wayne Fleischhacker, D.O.

Submitter : **Dr. Bakul Patel** **Date: 11/06/2006**

Organization : **Neurological care of Indiana**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

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

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

Sincerely,

(Bakul Patel, MD)

Submitter : **Dr. Robert Odell** **Date: 11/06/2006**

Organization : **Robert H. Odell, Jr., MD, PhD, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment. Thank you for the opportunity to submit a comment..Bob Odell, MD, PhD

CMS-1506-P2-1165-Attach-1.DOC

CMS-1506-P2-1165-Attach-2.DOC

#1165

November 6, 2006 Sent by EMAIL

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:

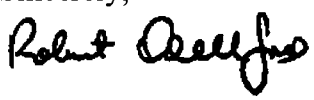
As a practicing interventional pain physician, I am quite concerned regarding CMS's proposed rule changes for ASC payments. Access for patients will definitely be harmed as the result of significant inequities being created between hospitals and ASCs. Interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% in 2009 and after) and it will be difficult to retain talented MDs and DOs in this specialty.

Multiple solutions have been proposed in the rule with regards to mixing and improving the case mix. These solutions are not really appropriate for single specialty centers such as pain management centers. As you know, CMS serves as a model for other insurance company reimbursement strategies in general healthcare uses. Medicare's decisions are the primary indicators for other payers. Other companies follow with their cuts, and Medicare will have removed any incentive for other insurers to pay appropriately. This will further limit access for the patient in pain. Considering that pain is the single greatest reason that people seek physicians (except for URI's), these regulations will have a chilling effect on access for everyone in pain.

Surgery centers must be reimbursed at the very least at the present rate with no further cuts. CMS should establish a fair and reasonable conversion factor that appropriately reflects the costs associated with an ASC for interventional techniques. Based on the above reasoning, the proposed changes should not be implemented. Although I do not know the details, I have been told that there are multiple other proposals to achieve this, i.e. preservation of surgery center reimbursement. At the very least, Congress should repeal the previous mandate and leave the system alone as it is now, or patients will lose access to pain physicians and needed procedures.

Please consider these arguments carefully. I will soon be 65 years old myself, and I frightened by some of the things I see happening. I trust that the arguments presented in this communication will be carefully considered so that the Medicare population will continue to have access to high quality care by high quiality pysicians at high quality facilities..

Sincerely,



Robert H. Odell, Jr.
Medical Director
Spine Pain Institute, La Quinta, CA

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

Organization : **Jervey Eye Group**

Category : **Physician**

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

Name: Christopher Myers, MD
ASC: Jervey Eye Center, Greenville, SC
%Medicare: 60%

The divisions described for commentary have me confused. I am writing to object to the payment rate for ASCs calculated to be 62% of Hospital Outpatient Surgery Departments. This proposal is short-sighted and erroneous, unless the goal is to protect hospital's incomes. ASC efficiency and care should be encouraged, not penalized. Make the reimbursement rates more equitable at 75%. This should be uniformly applied.

CB Myers,MD

ASC Inflation

ASC Inflation

Name: Christopher Myers, MD
ASC: Jervey Eye Center, Greenville, SC
Medicare Patients: 60%

It is incorrect to disallow any inflation adjustment for ASC reimbursement through 2009. Costs for materials and, more importantly, personnel, have risen as fast as the cost of medicine, a fact that should not require argument as one follows from the other. ASCs are required to change more rapidly and thus to maintain the highest, most current, standards. I am writing to object to this misguided strategy, one that balances the budget on the backs of ASCs to the benefit of hospital outpatient departments.

Sincerely,

CB Myers

ASC Unlisted Procedures

ASC Unlisted Procedures

Name: Christopher Myers, MD
ASC: Jervey Eye Center, Greenville, SC
Surgeries: Outpatient ophthalmic procedures
Medicare patients: over 60%

The list of procedures is restrictive and does not take into account the opinions of the people best able to accomplish a comfortable and successful result -- the patient and the doctor. Please expand the procedure list to aid in better care.

Sincerely, CB Myers

Submitter : **Dr. Terry Stambaugh** **Date: 11/06/2006**

Organization : **The Pain Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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
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Washington, DC 20201

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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,

Terry A. Stambaugh, M.D.

Submitter : Dr. Robert Zwolak **Date:** 11/06/2006

Organization : Society for Vascular Surgery

Category : Health Care Professional or Association

Issue Areas/Comments

ASC Office-Based Procedures

ASC Office-Based Procedures

SVS supports the CMS proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his/her specific condition. Physicians and patients should have the discretion to decide which setting is most clinically appropriate. For a patient whose safety requires general anesthesia or a sterile operating room, if an ASC is not an option, most physicians will elect to perform the procedure at a hospital, at greater cost to the Medicare program and to the beneficiary.

ASC Packaging

ASC Packaging

SVS believes it is essential that the new ASC payment system apply the OPPS packaging rules and pay ASCs the same way HOPDs are paid for items and services directly related to a surgical procedure. This would mean that payment for surgically implanted devices and implantable DME would be packaged into the facility fee for the procedure. Conversely, payment for drugs, biologicals, and diagnostic services directly related to performing a surgical procedure would not be packaged but, instead, would be paid separately. SVS members routinely provide contrast agents and radiology procedures, including invasive fluoroscopy and ultrasound procedures, even though the costs of some of these items and services are not explicitly covered by the ASC facility fee. Yet, the proposed rule essentially packages these costs by presuming they do not exist, thereby undermining a fundamental basis for applying the APC relative weights to ASCs. With regard to implanted devices and DME, we likewise agree that as a matter of sound payment policy, packaging of these items should be the same in ASCs and HOPDs.

SVS believes there should be maximizing alignment of the ASC and HOPD payment systems through use of a uniform conversion factor and the same bundles, annual updates and other relevant adjustments so that Medicare beneficiaries are able to understand their relative costs in each setting.
SVS believes that the ability of physicians to select the most appropriate site of service for their patients is of paramount importance. We agree that any procedure within the Surgery section of CPT should continue to be defined as a surgical procedure eligible for payment under the revised ASC payment system, regardless of whether it is office-based or requires relatively inexpensive resources to perform. We also note, however, that modern surgical techniques also include a number of radiology procedures that are invasive in nature but safely performed in ASCs. Examples include percutaneous transluminal angioplasty and stenting and the placement of catheters for therapeutic embolization. To allow for the efficient performance of these procedures in ASCs, we believe the revised ASC payment system s definition of surgical procedure should be expanded to include invasive radiology procedures (commonly referred to as interventional radiology) that require the insertion of a needle, catheter, angioplasty balloon, or stent through the skin into an artery or vein.
Similarly, procedures in the Medicine section of CPT that are invasive or intraoperative, or that require general anesthesia, also would be appropriately considered surgical services eligible for payment in ASCs. We recommend payment for CPT Category III and HCPCS Level II codes which crosswalk to or are clinically similar to procedures in the expanded definition of surgical procedures that we are suggesting. Since such codes are eligible for payment under the OPPS, they also should be eligible for payment under the new ASC payment system.

ASC Payable Procedures

ASC Payable Procedures

SVS supports the exclusionary list methodology: We support the CMS decision to adopt MedPAC's recommendation to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: 1) beneficiary safety; and 2) the need for an overnight stay. We agree that existing site-of-service volume and time limits are no longer clinically relevant, and that an exclusionary list reflects the best approach to balancing the need to protect beneficiary safety with the desire to increase beneficiary access to ASCs.

SVS recommends elimination or refinement of the Major Blood Vessel Exclusion: Among the safety criteria, CMS proposes to continue using procedures that involve major blood vessels as an exclusion. SVS notes that there is no uniformly agreed upon definition of major blood vessel , and there exist already within the current ASC coverage list several procedures that some experts would include as procedures involving a major blood vessel. Unless a procedure is inherently unsafe to perform on an outpatient basis (and thus a candidate for the OPPS inpatient-only list), we believe physicians are in the best position to determine the appropriate site-of-service based on the individual needs of their patients. SVS suggests that the major blood vessel criterion be dropped in favor of examining individual CPT procedures that involve arteries and veins for their likelihood of creating catastrophic bleeding in the event of an untoward complication. Specifically, the society would be very willing to work with CMS and other stakeholders in creation of a list of vascular services such as percutaneous angioplasty and stenting, which may well be performed safely in the ASC setting. We suspect that list will end up being similar of the HOPD approved list.
In the long run, we also suggest that the agency develop a reasonable process for gathering and evaluating reliable information about the safety of performing surgical procedures in ASC and HOPD settings as a basis for making informed decisions about the relative safety of the two sites-of-service in the future. This process could include an advisory committee of physicians with outpatient surgical experience who would meet prior to and following publication of the OPPS rule each year to advise CMS on coverage and safety issues. As a general rule, a procedure should not be excluded from coverage in an ASC or HOPD if, based on expert input from this advisory committee and informed public comments, it can be safely performed in an outpatient surgical setting pursuant to reasonable and generally accepted patient selection criteria, which are best applied by physicians applying their medical judgment, rather than CMS erring on the side of exclusion.

ASC Ratesetting

ASC Ratesetting

SVS supports ASC Ratesetting as a Percentage of the OPPS. SVS generally supports the proposal to base ASC payments on the APC groups and relative payment rates established under the OPPS. To better promote comparisons across sites of service, we believe it would be preferable to base payments to ASCs on a flat percentage of the payment for the same services established under the OPPS. We are concerned that the proposed use of a separate ASC conversion factor will be difficult for physicians to understand and, thus, will impede their ability to make direct comparisons on the basis of quality and price. We also urge CMS to further maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same multiple procedure payment reductions, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.

ASC Updates

ASC Updates

SVS supports annual updates. We are pleased that CMS is committing to annual updates of the new ASC payment system, and we agree it makes sense to do so in conjunction with the OPPS update cycle so as to help further advance parallels between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

Submitter : **Dr. Rodney Jones** **Date: 11/06/2006**

Organization : **Pain Management Associates**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Pain Management Associates, L.C.
825 N. Hillside, Suite 200, Wichita, Kansas 67214

November 06, 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 do not believe the proposed rule for ASC payments will improve access or quality of care for beneficiaries. If the payment scheme should be enacted as written, Interventional Pain Medicine will be dramatically affected. Interventional Pain Physicians attempt to raise the quality of care in an arena where poorly or non-trained mid level providers with much lower practice overhead and training costs directly compete. CMS payments to these individuals greatly undermines attempts by Interventional Pain Physicians to provide good medical care to CMS beneficiaries. Unfairly penalizing well trained physicians who are advancing a new and very much needed field I am sure is not the intent of the proposed payment to ASCs or its current reimbursement to mid level practitioners.

Please reverse the proposed reimbursement changes. Single specialty ASCs providing top notch Interventional Pain Management services will not be able to stay open if the proposed changes occur. Those centers do not have a balance of other cases with which to make up the losses. .

Sincerely,

Rodney L. Jones, M.D.

RLJ/pc

Submitter : **Dr. Tim McInnis** **Date: 11/06/2006**

Organization : **Same Day Surgery Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a co-owner of the only facility (an ASC) in a 100 mile radius that provides ophthalmological surgical services. Our facility provides other covered surgical services as well.
The proposed new ASC payment system is dysfunctional for many reasons, not the least of which are: 1) too restrictive of procedure list, 2) inadequate payment rate to cover costs in relation to the HOPD, 3) non-uniform HOPD rates across procedure types, and 4) lack of equitable (HMB) cost-of-living updates.
Please make the necessary changes in the proposed regulations so that we can continue to remain a viable business and cost effective surgical option to Medicare and Medicaid beneficiaries.
Tim J McInnis, MD
300 N Willson Ave, Suite 1003
Bozeman, MT 59715
mcdeye@in-tch.com

Submitter : **Dr. Andrew Sukiennik** **Date: 11/06/2006**

Organization : **Dr. Andrew Sukiennik**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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,

Andrew Sukiennik, M.D.