Submitter : Mr. Nicholas Adolf **Date:** 11/03/2006

Organization : Davita Inc.

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Thank You,

Nicholas Adolf RN, BSN

Submitter : **Mrs. Andrea Hyatt** **Date: 11/03/2006**

Organization : **Dulaney Eye Institute**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

November 3, 2006

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

Dear Administrator Norwalk:

I am an administrator of an ophthalmic ambulatory surgery center in Towson, MD. Our center specializes in cataract, glaucoma and retina procedures. Our main focus for the almost twelve years our doors have been open, is providing a high-quality, cost-effective, customer-focused place to have surgery. Our surgery center, and others like ours, plays an important role in helping constrain health care spending dollars.

I am writing you today to share my concern over the proposed rule and HR4042/S1884. Aligning the payment systems for ASC s and hospital outpatient departments will certainly 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 by the law will maximize the benefits to the Medicare beneficiary. However, while attempting to obtain budget neutrality, the proposed 62% of HOPD rates is not adequate payment for many procedures performed in ASC s.

In single specialty ASC s such as ours, limited procedures are performed. The advantage for the patient has always been the level of expertise of an anesthesia and nursing staff, which can concentrate on excelling at just one specialty. The downside is that any reduction of payment for even just one procedure can destroy the economic stability of the center. In addition procedures slated for higher reimbursement in the proposed ruling, may actually take a loss due to the bundling of supplies and implants into those codes.

I urge CMS to sharpen their pencils to determine a percentage rate of the HOPD that won t hurt the industry that has saved them and their beneficiaries millions of dollars each year.

Thank you in advance for your consideration in this matter.

Sincerely,

Andrea M. Hyatt, CASC

#804

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
East Brunswick, NJ 08816
Tel: (732) 432-6880 Fax: (732) 432-6885

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare & Medicaid Services
Dept. 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 a private practice physician who presently treats Medicare beneficiaries in my practice. I am writing to express my grave concern with CMS's recent proposal to change the way the agency pays ambulatory surgery centers for their services, via facility fee payments.

In my practice, we see a large number of Medicare patients. Treatment for a substantial percentage of these patients includes performing screening colonoscopies for those who are at average risk for colorectal cancer, as well as colonoscopies for high risk individuals and surveillance colonoscopies for those who have already been detected as having either polyps, or who have had cancerous lesions excised previously. Additionally we see a very significant number of patients with other conditions—GI bleeding, inflammatory bowel disease, gastroesophageal reflux disease (GERD), and/or Barrett's esophagus for whom ready access to an appropriate, safe, cost-efficient site for GI endoscopy is critical to either restoring them to good health, or sustaining them in good health.

Because of these reasons it is imperative that the current reimbursement payment system remain in effect. We can ill afford a reduction in the current rate in order to continue providing the highest quality of care to our Medicare beneficiaries.

The following points should be taken into consideration:

- To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 60% 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 a HOPD. CMS should exclude only those procedures that are on the inpatient only list.

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Having dealt a death-blow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

With fewer ASCs, a larger proportion of all GI procedures will need to be performed in the HOPD, where the facility fees CMS pays will be higher.

So, the inevitable result of this proposed CMS action, if implemented will be: (a) total Medicare costs for GI facility fees will rise (although the per unit facility fee for decreased number of these performed in the ASC may well decline); (b) available access by Medicare beneficiaries for GI colonoscopies and other endoscopic procedures will decline; and (c) more Medicare beneficiaries will die unnecessarily from colorectal cancer will increase as screening rates decline.

It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

Allan B. Plumser, MD
aplumser@aol.com

Submitter : Dr. Mitchell Ferges **Date:** 11/03/2006

Organization : Endosurgical Center of Central NJ

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1506-P2-805-Attach-1.DOC

#805

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
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Tel: (732) 432-6880 Fax: (732) 432-6885

November 3, 2006

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

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It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

Mitchell Ferges, MD

Submitter : Dr. Raymond Fong **Date:** 11/03/2006

Organization : New York Eye Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

My comments are attached.

CMS-1506-P2-806-Attach-1.DOC

#806

RAYMOND FONG, M.D., P.C.
RAYMOND FONG, M.D.
BINGJING Z. ROBERTS, M.D.
MELISSA LEUNG, M.D.
JAY FLEISCHMAN, M.D.
DONGSIK KIM, O.D.
ELZIE CHAN, O.D.
DAVID YIP, O.D.

NEW YORK EYE CENTER

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Fax: (718) 762-3801

November 2, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, D.C. 20201

Attention: CMS-1506-P, Room 445-G

Dear Administrator Norwalk:

This letter is in regard to the Notice of Proposed Rulemaking published on June 12, 2006 regarding updates to the rate-setting methodology, payment rates, payment policies and the list of covered surgical procedures for ambulatory surgery centers. As a surgeon who utilizes ambulatory surgery almost exclusively, I am submitting the following comments in the interest of creating a healthcare system that delivers excellent clinical outcomes in a cost-efficient environment:

- The Centers for Medicare and Medicaid Services' proposed reform of the ambulatory surgery center procedures list remains far too restrictive. The expansion of the list to include any and all procedures that can be performed in a hospital outpatient department will result in migration of services from one site of service setting to another.

- The decision as to the site of surgery should be made by the surgeon in consultation with his patient. The Centers for Medicare and Medicaid Services' proposal to limit the physician's ability to determine the appropriate site of service for a procedure excludes many surgical procedures appropriate for the ambulatory surgery setting.

- Ambulatory surgery centers should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in hospital outpatient departments. When hospital outpatient departments perform services or procedures for which specific codes are not provided, they use an unlisted procedure code, identify the service and receive payment. I believe ambulatory surgery centers should also be eligible to utilize this process.

- Proposing to pay ambulatory surgery centers only 62% of the procedural rates paid to hospital outpatient departments does not reflect a realistic differential of the costs incurred by ambulatory surgery centers and hospitals in providing the same services. The budget neutrality provision should be interpreted to permit ambulatory surgery centers to be paid at a rate of 75% of the hospital outpatient department rate as recommended by the ambulatory surgery center industry. Such interpretations should include all hospital outpatient department payments in addition to just ambulatory surgery center payments. Broadly interpreting the budget neutrality requirement imposed by Congress would provide Medicare beneficiaries with access to ambulatory surgery centers, thereby reducing Medicare costs.

- The percentage that is eventually adopted by the Centers for Medicare and Medicaid Services in the final regulation should be applied uniformly to all ambulatory surgery center services, regardless of the type of procedure or the specialty of the facility.

- Although the Centers for Medicare and Medicaid Services has added many ophthalmic services to the ambulatory surgery list, it would pay for many office-type services, like laser procedures, at the Medicare Professional Fee Schedule practice expense amount, i.e., your current reimbursement rate, rather than at the 62% rate. As noted above, whatever percentage is ultimately adopted it should be applied uniformly to all services, regardless of type. Most such services will also be transferred from the hospital outpatient department to the ambulatory surgery center setting thereby reducing Medicare costs and offsetting possible increased costs on the shifting of such services from office to ambulatory surgery center.

- Ambulatory surgery centers should be updated based upon the hospital market basket because it more appropriately reflects inflation in providing surgical services than does the consumer price index. The same relative weights should be used for ambulatory surgery centers and hospital outpatient departments since both provide the same services and incur the same costs in delivering surgical care.

- Aligning the payment systems for ambulatory surgery centers and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. 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.

- The cap on office-based payments is inappropriate for the ambulatory surgery center and should be omitted from the final regulation.

- Devices used for surgical procedures should be included in the global fee.

- Ambulatory surgery centers should be eligible to receive new technology pass-through payments.

- The computation of rates and rate changes should be the same for both the hospital outpatient department and ambulatory surgery center reimbursement.

In summary, my firm belief is that the proposed changes to the ambulatory surgery center payment policies contain serious flaws that must be addressed in order to keep the Medicare program viable for ambulatory surgery centers. I urge that your serious attention be given to the items discussed above and I thank you for your time reviewing this correspondence.

Sincerely,

Raymond Fong, M.D.

Submitter : Dr. Satya Kastuar **Date:** 11/03/2006

Organization : Endosurgical Center of Central NJ

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1506-P2-807-Attach-1.DOC

#807

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
East Brunswick, NJ 08816
Tel: (732) 432-6880 Fax: (732) 432-6885

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare & Medicaid Services
Dept. 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:

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Because of these reasons it is imperative that the current reimbursement payment system remain in effect. We can ill afford a reduction in the current rate in order to continue providing the highest quality of care to our Medicare beneficiaries.

The following points should be taken into consideration:

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Respectfully submitted,

Satya Kastuar, MD

Submitter : Dr. Ira Merkel **Date:** 11/03/2006

Organization : Endosurgical Center of Central NJ

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-808-Attach-1.DOC

#805

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
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November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare & Medicaid Services
Dept. 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:

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Respectfully submitted,

Ira Merkel, MD

Submitter : **Dr. Alexander Rapisarda** **Date: 11/03/2006**

Organization : **Endosurgical Center of Central NJ**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-809-Attach-1.DOC

#809

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
East Brunswick, NJ 08816
Tel: (732) 432-6880 Fax: (732) 432-6885

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
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Washington, DC 20201

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Respectfully submitted,

Alexander Rapisarda, MD

Submitter : Dr. Kevin Skole **Date:** 11/03/2006

Organization : Endosurgical Center of Central NJ

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-810-Attach-1.DOC

#810

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
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November 3, 2006

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Dept. of Health and Human Services
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Respectfully submitted,

Kevin Skole, MD

Submitter : Dr. Steven Lenger **Date:** 11/03/2006

Organization : Endosurgical Center of Central NJ

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-811-Attach-1.DOC

#811

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
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November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
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Because of these reasons it is imperative that the current reimbursement payment system remain in effect. We can ill afford a reduction in the current rate in order to continue providing the highest quality of care to our Medicare beneficiaries.

The following points should be taken into consideration:

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So, the inevitable result of this proposed CMS action, if implemented will be: (a) total Medicare costs for GI facility fees will rise (although the per unit facility fee for decreased number of these performed in the ASC may well decline); (b) available access by Medicare beneficiaries for GI colonoscopies and other endoscopic procedures will decline; and (c) more Medicare beneficiaries will die unnecessarily from colorectal cancer will increase as screening rates decline.

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Respectfully submitted,

Steven Lenger, MD

Submitter : **Dr. Brian Katz** **Date: 11/03/2006**

Organization : **Endosurgical Center of Central NJ**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-812-Attach-1.DOC

#812

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
East Brunswick, NJ 08816
Tel: (732) 432-6880 Fax: (732) 432-6885

November 3, 2006

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

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Respectfully submitted,

Brian Katz, MD

Submitter : **Dr. James Judy** **Date: 11/03/2006**

Organization : **Urological Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I oppose the proposal for office based reimbursement CAP. I've been in practice for 32 years and have gone through the transition from admitting patients for every procedure to doing most of our procedures in an outpatient setting. Actually when I first started practice, medicare would only pay if the patient spent the night.

As a result of this, ASC's have been developed. Ask any phycisian involved in an ASC if they wanted to go back to the hospital or office setting. We are much more efficient and ultimately the patients benefit from these efficiencies.

Our patients have their procedure in a much more timely manner and are dealing with a staff that usually work only in their facility. The staff knows our procedures and the equipment that is needed.

Ambulatory Surgery Centers just don't happen. To become operational, it requires a great deal of planning and capital. I really feel it is short sighted to consider basing the reimberssment on a office based setting.

I also encourage that ASCs reimbursement be the same as the hospital outpatient care. To remain open we have the same intensive requirements as the hospital and director of our facility I review any variancies and strive to be sure our staff is knowlegable of the requirements and daily operation.

I also would recommend that all approval procedures on the ASC list remain on the list. Patients are use to this and appreciate the efficiencies of our ASC. This is very important because our patients are dealing with medical issues and the apprehension that is inherent regarding their health.

Thank you for your consideration.

James C. Judy, MD

Submitter : **Dr. Dr. Paul Ellis** **Date: 11/03/2006**

Organization : **The Urology Center of Spartanburg**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

To whom it may concern,

As a practicing urologist in the state of South Carolina, I am writing to ask that you exempt all urologic procedures that are presently on the ASC list from the office based classification method of reimbursement. A significant part of my practice includes performing urologic procedures in an ambulatory surgery center (ASC).

I perform prostate biopsies and cystoscopies in the ASC on a regular basis and have been doing so for the past 3 years. Prior to 3 years ago I performed these 2 procedures in the office. I have many patients who have had these procedures performed in both settings and, when asked where they prefer having these procedures performed, the overwhelming response is that they preferred the ASC. They report that they had more pain and negative memories from these procedures when they were done in the office.

These procedures are very uncomfortable and the use of intravenous sedation or monitored anesthesia makes a big difference in patient comfort. When we were performing cystoscopies and prostate biopsies in the office we were losing many of these patients to our competitors (who used an ASC for these procedures) because of the discomfort they were experiencing. From personal experience, I do not feel that IV sedation/anesthesia can be safely administered in the office setting but can be safely (and cost effectively) administered in an ASC. With the proposed changes in ASC rates for cystoscopy(52000) and prostate biopsy(55700) we will effectively be forced to perform these procedures in the office for patients with Medicare which, I feel, is a huge disservice to this patient population.

I would also object to the proposal by CMS to pay ASCs a much lower rate than hospital outpatient departments for procedures that involve high cost technology such as lithotripsy(50590) and laser treatment of the prostate(52647,52648). The ASC incurs the same lease expense (if not more) than the hospital for these procedures and this expense makes up the bulk of the facility expense. The same holds true for procedures involving high cost prosthetics such as penile prosthetics and artificial urinary sphincters. This measure would only encourage us to perform these procedures in the hospital setting which would place more financial strain on CMS. This seems short-sighted and penny wise but pound foolish .

Ambulatory Surgery Centers are a cost effective environment for providing comfortable, quality health care to all of our patients. It would be a shame if we are forced to exclude Medicare recipients to a less tan optimal experience (in the office) or more expensive environment (in the hospital) for certain procedures. Please consider this when you make your decision.

Sincerely,

Paul T. Ellis
Urology Center of Spartanburg
Spartanburg, SC 29303

Submitter : Dr. Rajiv Uppal **Date:** 11/03/2006

Organization : Advanced Endoscopy and Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attachment

CMS-1506-P2-815-Attach-1.DOC

#815

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
East Brunswick, NJ 08816
Tel: (732) 432-6880 Fax: (732) 432-6885

November 3, 2006

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

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Respectfully submitted,

Brian Katz, MD

Submitter : Dr. Howard Guss **Date:** 11/03/2006

Organization : Advanced Endoscopy and Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attachment

CMS-1506-P2-816-Attach-1.DOC

#816

ENDOSURGICAL CENTER OF CENTRAL NJ

800 Ryders Lane
East Brunswick, NJ 08816
Tel: (732) 432-6880 Fax: (732) 432-6885

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare & Medicaid Services
Dept. of Health and Human Services
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Hubert H. Humphrey Building
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Respectfully submitted,

Brian Katz, MD

Submitter : Dr. Steven Gorcey **Date:** 11/03/2006

Organization : Advanced Endoscopy and Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attachment

CMS-1506-P2-817-Attach-1.DOC

#817

Advanced Endoscopy and Surgical CENTER

142 Route 35 South
Suite 101
Eatontown, NJ 07724
Tel: (732) 935-0031 Fax: (732) 935-0032

November 3, 2006

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

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Respectfully submitted,

Steven Gorcey, DO

Submitter : Dr. Thaddeus Grabowy **Date:** 11/03/2006

Organization : Advanced Endoscopy and Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attachment

CMS-1506-P2-818-Attach-1.DOC

#818

Advanced Endoscopy and Surgical CENTER

142 Route 35 South
Suite 101
Eatontown, NJ 07724
Tel: (732) 935-0031 Fax: (732) 935-0032

November 3, 2006

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Respectfully submitted,

Thaddeus Grabowy, MD

Submitter : Dr. Thomas Fiest **Date:** 11/03/2006

Organization : Advanced Endoscopy and Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attached

CMS-1506-P2-819-Attach-1.DOC

#819

Advanced Endoscopy and Surgical CENTER

142 Route 35 South
Suite 101
Eatontown, NJ 07724
Tel: (732) 935-0031 Fax: (732) 935-0032

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
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Dept. of Health and Human Services
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Respectfully submitted,

Thomas Fiest, MD

Submitter : Dr. Beverly Avendano **Date:** 11/03/2006

Organization : Advanced Endoscopy and Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attached

CMS-1506-P2-820-Attach-1.DOC

#820

Advanced Endoscopy and Surgical CENTER

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November 3, 2006

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- 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 a 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 con summer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments.

- Aligning the payment systems for ASCs the 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.

Having dealt a death-blow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

With fewer ASCs, a larger proportion of all GI procedures will need to be performed in the HOPD, where the facility fees CMS pays will be higher.

So, the inevitable result of this proposed CMS action, if implemented will be: (a) total Medicare costs for GI facility fees will rise (although the per unit facility fee for decreased number of these performed in the ASC may well decline); (b) available access by Medicare beneficiaries for GI colonoscopies and other endoscopic procedures will decline; and (c) more Medicare beneficiaries will die unnecessarily from colorectal cancer will increase as screening rates decline.

It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

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