Submitter : Dr. George Wade **Date:** 11/03/2006

Organization : Orthopedic Surgery Center of Idaho

Category : Ambulatory Surgical Center

Issue Areas/Comments

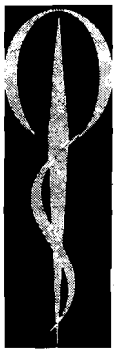
CY 2008 ASC Impact

CY 2008 ASC Impact

See Attached

CMS-1506-P2-872-Attach-1.DOC

#872



ORTHOPEDIC
SURGERY
CENTER OF
IDAHO

1425 W River
Boise, ID 83702-6861

208-342-1932
208-336-1954 (fax)

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Proposed Medicare Payment Changes

My name is George Wade, MD and I am a physician owner of the Orthopedic Surgery Center of Idaho in Boise, Idaho. Our ambulatory surgery center (ASC) offers orthopedic surgical services and has been providing high quality, patient centered, and cost effective interventional procedures and surgery since February 2002. Our 28 employees and 20 surgeons care for approximately 3200 patients a year (this includes over 340 Medicare beneficiaries) at our surgery center. I am taking this opportunity to offer our concerns regarding the payment rates for ASCs proposed by the Centers for Medicare and Medicaid Services (CMS).

In 2008, CMS essentially proposes to pay ASCs 38 percent less than what they pay a hospital for the exact same surgical procedure. This untenable price differential, which will widen further over time, is unrelated to the costs that ASCs incur in delivering services. It is driven entirely by the agency's narrow interpretation of budget neutrality requirements and will jeopardize the ability of many ASCs to continue to provide high quality surgical care to Medicare beneficiaries. (The ASC industry recommends that ASCs be paid at 75% of hospital rates.)

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost 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. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient department services (HOPD) were not extended to the ASC setting, and these 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 the beneficiary more than necessary.

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

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under Outpatient Payment System (OPPS); ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

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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. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary.

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We strongly feel there is a better way to design the new ASC payment system, and would like the Centers for Medicare and Medicaid (CMS) to work with the ASC industry to find a more equitable system. Thank you for allowing us the opportunity to share our concerns.

Sincerely,

George Wade, MD

Submitter : Dr. Robert Walker **Date:** 11/03/2006

Organization : Orthopedic Surgery Center of Idaho

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-873-Attach-1.DOC

CMS-1506-P2-873-Attach-2.DOC

#813

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Sincerely,

Robert Walker, MD

Submitter : Dr. Stanley Waters **Date:** 11/03/2006

Organization : Orthopedic Surgery Center of Idaho

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-874-Attach-1.DOC

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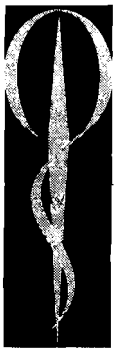

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Sincerely,

Stanley Waters, MD

Submitter : Dr. Troy Watkins **Date:** 11/03/2006

Organization : Orthopedic Surgery Center of Idhao

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

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#875

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Sincerely,

Troy Watkins, MD

Submitter : **Dr. Dean Gambino** **Date: 11/03/2006**

Organization : **Mesa Surgical Partners**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

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Thank you for this opportunity to comment on changes for the proposed Medicare reimbursement rates for ambulatory surgery center surgeries for 2008.
The concept of a surgery center for outpatient surgery has been exceedingly successful in reducing the cost of medical care whilc maintaining cxcellence in outcome and efficiency. The proposed cots will have a very negative impact upon patient's and outpatient surgery centers to continue to provide outstanding care for our outpatients. I strongly recommended she reconsidered these draconian cuts in order to preserve one of the truly efficient deliveries of medical care in the United States. As reimbursements continue to dwindle for physicians caring for Medicare patients we are facing a crisis soon to be realized by inability for our Medicare population to obtain adequate medical care.

Thank you for your time and I know that she will give careful consideration to these issues.

Dean R. Gambino, M.D.
Email dgamb58@cox.net

Submitter : Dr. Somasundaram Bharath **Date:** 11/03/2006

Organization : Altru Clinic Lake Region

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

ASC

Submitter : **Mia Hippler** **Date: 11/03/2006**

Organization : **ORegon Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

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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 the majority of ASCs will suffer substantially - approximately 20% in 2008 and approximately 30% reduction in payments in 2009 and thereafter. At these reduced reimbursement rates, many ASC will go out of business and will reduce Medicare patients choice for surgeries and procedures.

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,

Mia Hippler

Submitter : Dr. Heath Lemley **Date:** 11/03/2006

Organization : Regional Eye Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-879-Attach-1.DOC

#819

11/1/2006

Centers for Medicare and Medicaid Services
CMS-1506-P
Department of Health and Human Services
Attention: CMS-1506-P
P.O.Box 8011
Baltimore, MD 21244-1850

Dear CMS:

I am writing to you regarding the proposed regulation to establish a new ASC payment system and update of the ASC procedures list (CY 2008 ASC Impact).

Who We Are
Our small facility (Surgical Eye Center of Morgantown), utilizing only one of two ORs, has provided a full range of ophthalmic services to Medicare beneficiaries in our area for almost 10 years. Our estimate is that we have saved Medicare and Medicaid, close to $2,000,000 in payments by using our free standing facility in this ten year period. In addition to being the most cost effective center in the area, we also provide the highest possible quality of care, and are easily accessible to a large area. We have been the most successful joint venture with our community hospital of any physician – hospital cooperative effort in the area. This success is not measured in financial terms, but in the quality of care, efficiency and cost effectiveness of any similar service. Our patients continually rate us superior in various surveys 98% of the time.

Equity in Services Provided
ASCs should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in HOPDs. Now is the time with this opportunity to allow ASCs equal latitude of performing the same procedures allowed in HOPDs. The savings to Medicare will be very significant.

Outrageous Proposed Rate of 62% of HOPDs
Claiming Budget Neutrality to propose a 62% reimbursement rate will result in shutting down most of the small ASCs (ours included) that have been providing large savings to CMS already. Even at a rate of 75% (recommended by the ASC industry), it will be a stretch for our center to survive. It appears that the Hospital Association is in favor of this new lower rate (62%) as they know many ASCs will close, and they will then be able to provide the services at a much higher rate than ASCs do – and this would be under Part A Medicare, not Part B.

The Reimbursement Shift
If you are looking at Budget Neutrality, you must take the projected dollars saved in Medicare Part A and transfer these dollars into the ASC reimbursement levels – that is in fact in Medicare Part B. Otherwise this will become yet another method of shifting services out of Part A into Part B without the shift of equivalent dollars realized in the savings. Physician providers can simply not absorb any more of this revenue shift that has been occurring for over 10 years.

Facts are Facts
Fact # 1 – Our nurses do not work for 62% of what the hospital pays.

Fact # 2 – We do not get special consideration for our electric bills (or other utilities) at 62% of what hospitals pay (or at any discount).
Fact # 3 – Our construction/facility costs are not 62% of what a hospital pays.
Fact # 4 – Our certification process does not cost 62% of what hospitals pay.
Fact # 5 – Our equipment, instruments, surgical packs and other supplies do not come at 62% of what hospitals are paid, in fact they are much higher due to the low volumes.
Fact # 6 – ASCs are more efficient and proven higher quality than hospitals, and this would seem opposite of the Pay For Performance move in the government.
Fact # 7 – Paying 62% of what hospitals are paid will destroy most small ASCs and severely curtail services for beneficiaries.

Annual Updates of Payment Rates
ASCs currently are not entitled to any cost-of-living updates (2004 – 2009), despite the fact that our costs actually do go up, just like hospitals. CMS is proposing to pay ASCs updates that are going to be less than hospital updates (CPI vs HMB). This will eventually cause a shift of cases back to the hospitals where it is more expensive and does not measure up to the quality provided in ASCs. Additionally, this will result in a dramatic decrease in accessibility for CMS beneficiaries as hospitals are not nearly as efficient as ASCs.

Final Thought
I have practiced Medicine for over 10 years and faced many clinical and practice challenges. I have seen a lot happen in that time. I have always strived to provide the highest quality, cost effective and accessible care to all of my patients. **If this proposal succeeds, I guarantee you that it will result in lower quality, higher cost and less accessible care for those in need.**

My partners and I urge you to consider our comments seriously as we would really like to practice medicine and take care of our patients. Please do not impede our efforts.

Thank you for your consideration,

Sincerely,

Heath L. Lemley, MD
Surgical Eye Center of Morgantown
1299 Pineview Dr.
Morgantown, WV, 26505

Submitter : **Date: 11/04/2006**

Organization : **USPI**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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.

ASC Payable Procedures

ASC Payable Procedures

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.

Submitter : **Date: 11/04/2006**

Organization : **USPI**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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 : **Date: 11/04/2006**

Organization : **USPI**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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.

Submitter : **Date: 11/04/2006**

Organization : **USPI**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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 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.

Submitter : **Date: 11/04/2006**

Organization : **USPI**

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.

Submitter : **Date: 11/04/2006**

Organization : **USPI**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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.

Submitter : **Date: 11/04/2006**

Organization : **USPI**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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.

Submitter : **Date: 11/04/2006**

Organization : **USPI**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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 advanee 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 : Mrs. Linda Dudley **Date:** 11/04/2006

Organization : Riverside Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Unlisted Procedures

ASC Unlisted Procedures

CMS should increased the procedure listing for ASC's to include all services provided in hospital outpatient settings with the exception of those that may required overnight stays.

Submitter : Dr. Ali Keshavarzian **Date:** 11/04/2006

Organization : Rush University Medical center

Category : Physician

Issue Areas/Comments

ASC Office-Based Procedures

ASC Office-Based Procedures

I will not be able to serve my patients and survive finanacially with the new changes. My cost will be more than the proposed revenue.

ASC Payable Procedures

ASC Payable Procedures

I will not be able to serve my patients and survive finanacially with the new changes. My cost will be more than the proposed revenue.

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

I will not be able to serve my patients and survive finanacially with the new changes. My cost will be more than the proposed revenue.

Submitter : **Dr. William Stevens** **Date: 11/04/2006**

Organization : **Digestive Disease Associates of Dallas**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

November 2, 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;

My name is Susan Stroman, CPA and I currently serve as the Administrator of Dallas Endoscopy Center in Dallas, Texas. Our ambulatory surgery center offers endoscopy services and has been providing high quality, patient centered, and cost effective interventional procedures and surgery since 2005. Our 18 employees and over 13 surgeons care for approximately 6,600 patients a year (this includes approximately 2,640 Medicare beneficiaries) at our surgery center.

I would like to share with you the costs that are involved in running our surgery center and how CMS's proposed cut in fees to surgery centers will be detrimental not only to ASC's but to CMS and Medicare patient's in particular.

CMS now reimburses the hospital for a diagnostic colonoscopy done in the hospital outpatient surgery setting $542.53 and they reimburse ASC's $446.00. The proposed CMS rule states that it is trying to achieve transparency and neutrality between ASC and hospital reimbursement yet instead of proposing an increase in fees to the surgery center to meet the hospital reimbursement, they are proposing a cut to $349.82 for a colonoscopy performed at an ASC.

As you can see this is not a move towards neutrality or transparency and further more the amount of reimbursement that is being proposed is less than our cost to perform a procedure. If CMS moves our fee to their proposed $349.82 for a colonoscopy our physicians will be forced to do the procedure in the hospital setting which, as you can see from the numbers, costs' CMS more money since they reimburse the hospital at a much higher level.

In the proposed rule by CMS, CMS spends a lot of time describing its reasoning for the methodology used to determine that hospital APC (procedure code) coding and rates would be used to set ASC reimbursement. The argument is that there have been many years of study going into all the factors that make up the relative value of each APC. While this may be a fair assessment, they do not follow thru with proposing the same reimbursement for the ASC as the hospital.

If CMS feels that the hospital needs to be reimbursed more because it runs an emergency room and many other services that they do not get sufficient funds from then, they need to reimburse these areas at a greater amount and reimburse other procedures at their true relative value, if they truly want to be transparent and fair.

I would really like to be involved in helping you understand the issues involved with this matter and how large of an impact to Medicare and Medicare patients it would be if ASCs had to shut down and all procedures be performed in the hospital. We do patient satisfaction surveys at our center and have found that 90% or better, of our patients, would choose again to have their procedure performed in the surgery center setting. Surgery centers are safe and convenient for the patient and also saves the patient and the healthcare system money.

Please let me know if I could meet with you to discuss this issue further. Thank you for your time and consideration

William E. Stevens, M.D.

Digestive Disease Associates of Dallas
Dallas Endoscopy Center
214-345-7932
214-345-4264 fax

Submitter : Dr. Gundala Reddy **Date:** 11/04/2006

Organization : Interventional Pain Center of Merced

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1506-P2-891-Attach-1.DOC

#891

Gundala S. Reddy, MD
1390 E. Yosemite Ave, Suite C
Merced, CA 95340-8221

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, CC to Rep. Dennis Cardoza

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 and helping the elderly in the United States.

Sincerely,

Gundala S. Reddy

Submitter : Dr. steven wertheim **Date:** 11/04/2006

Organization : resurgens orthopaedics

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

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 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.

ASC Packaging

ASC Packaging

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 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.

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 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 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. Julieta Golser **Date:** 11/04/2006

Organization : Mid Columbia Kidney Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Improved Vascular Access Accesibility to ASC Setting and Support Our Fistula First Initiative.

Submitter : **Mrs. Michelle Hollingsworth** **Date: 11/05/2006**

Organization : **Davita Altus Dialysis 889**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Vascular access for dialysis patients is simply their lifeline. In remote areas such as Altus, OK, there are no facilities within 2 hours of us for our patients for vascular access. It is difficult for them to get their accesses, and get them fixed when they go wrong. I feel as though there should be a clinic here, maybe the outpatient clinic at the hospital here, that has a surgeon to do access procedures. Not full time, but somone who is willing to come in one day a week to help these patients and those who need it in this area.
Thank You,
Michelle Hollingsworth
580-482-1197
Altus Dialysis

Submitter : John McClanahan **Date:** 11/05/2006

Organization : Cochlear Americas

Category : Device Industry

Issue Areas/Comments

ASC Packaging

ASC Packaging

Cochlear" Americas, the world s largest manufacturer of auditory osseointegrated and cochlear implants, welcomes the opportunity to comment on CMS proposed rule for the ambulatory surgical center payment system included in CMS-1506-P2. Cochlear s primary concern is the proposed packaging policy to pay for device-dependant procedures, in particular the CMS proposal to pay 62% of the conversion factor for comparable procedures currently paid under OPPS.

Although cochlear implantation is an ASC approved procedure, few have been implanted in that setting due to the extremely poor device payment rate under DMEPOS, i.e., regardless of state or region, device payment is below $16,000. In 2005, the average selling price for a cochlear implant system was $24,900. Although Cochlear implants have been paid under OPPS since 2000, OPPS rate setting methods have yet to accurately account for the cost of the device.

Implantation of an auditory osseointegrated device is also an ASC covered procedure, however Medicare only recently approved it for pass-through payment under OPPS (effective January 1, 2007.) The CMS proposal for ASC payment in 2008 will have a profound impact on future payment for auditory osseointegrated implants in that setting.

Both procedures are device-dependent in that the sole purpose of the procedure is the insertion of the implantable prosthetic. Under CMS proposal, any costs that the ASC may have previously received for implantable devices and prosthetics associated with device-dependant procedures will be packaged. The CMS proposal to package the cost of these devices into the ASC facility fee will lead to a significantly reduced payment for these procedures if: 1) rate-setting methodology is not allowed to transition effectively, that is, for more than 2 years if needed, and 2) does not accurately aceount for the device and facility costs. The CMS proposal paying 62% of OPPS payment in the face of the historically imprecise analysis of device costs compromises the ability of ASCs to eover the costs of implantable devices. Further, establishing different bundling policies in each setting may lead to different relative payment amounts in the different settings in spite of similar device acquisition costs.

The proposed CMS methodology also does not take into account the unique costs incurred by the ASCs for device-dependent procedures. Cochlear encourages CMS to avoid using established hospital outpatient payment rates as a basis for setting ASC rates in situations where external data challenges the accuracy of these rates. In spite of recent eligibility for pass-through payment, the newness of the procedure to implant the auditory osseointegrated device and the historical irregularities associated with hospital reporting costs associated with OPPS procedures lead us to recommend an alternative payment approach for implantable prosthetics procedures performed in the ASC setting. Therefore, Cochlear recommends that the methodology allow for direct billing of acquisition costs plus an administrative fee for device-dependent ASC procedures.

In conclusion, Cochlear requests that CMS depart from the methodology it has proposed to price device dependent procedures performed in ASCs. Instead of discounting a too-low APC payment rate, CMS should allow for the direct billing by ASCs of implantable hearing prosthetics and establish a separate ASC payment rate for the non-technology ASC facility costs that are incurred.

Implementing CMS proposed packaging policy might cause many device-dependant procedures to shift back to the more expensive outpatient department. Cochlear recommends that CMS make appropriate adjustments to the ASC payments to ensure the cochlear implants and auditory osseointegrated implants are reimbursed in a manner that makes it feasible to perform the procedures in an ASC.

Submitter : Dr. William J. Fishkind, MD **Date:** 11/05/2006

Organization : Fishkind and Bakewell Eye Care and Surgery Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-896-Attach-1.TXT

#896

November 5, 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:

The Fishkind and Bakewell Ambulatory Eye Surgery Center is an ASC attached to the Fishkind and Bakewell Eye Care and Surgery Center Campus. We have been providing high quality, patient centered and cost-effective ophthalmic laser and surgical services since 1987 and we care for more than 3000 patients a year, over 85% of who are Medicare beneficiaries.

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. 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,

William J. Fishkind, MD, FACS
Surgeon Co-Director

Submitter : Dr. Brett Coldiron **Date:** 11/05/2006

Organization : American Academy of Dermatology Assn

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-897-Attach-1.DOC

#897

American Academy of Dermatology Association

Physicians Dedicated to Excellence in Dermatology®

Stephen P. Stone, MD, FAAD
President

Diane R. Baker, MD, FAAD

David M. Pariser, MD, FAAD

William P. Coleman, III, MD, FAAD

Mary E. Maloney, MD, FAAD

Henry W. Lim, MD, FAAD

Ronald A. Hennchs, CAE

Phone
Fax
Web Site

November 6, 2006

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

Re: CMS-1506-P2 - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

On behalf of the 15,000 members of the American Academy of Dermatology Association (AADA), I appreciate the opportunity to submit written comments regarding proposed changes in the Ambulatory Surgical Center (ASC) Payment System. As advocates for dermatologists and their patients, the Academy firmly believes that an adequate ASC payment schedule should ensure fairness and continued beneficiary access to safe, quality specialty health care services in the setting of their choice.

The Centers for Medicare and Medicaid Services (CMS) should be commended for expanding the procedures payable in ASCs to allow a much broader range of services for beneficiaries in this site of service. The Academy agrees with the Medicare Payment Advisory Commission's (MedPAC) recommendation that CMS should seek congressional authority to replace the current inclusionary list of ASC services with an exclusionary list. This is a similar concept to the list of procedures excluded from payment in hospital outpatient departments (HOPDs).

Unfortunately, the proposed rule will create significant inequities between hospitals and ASCs, and ultimately will harm beneficiary access to specialty health care services, such as those provided by dermatologists. CMS, citing budget neutrality restrictions imposed by Congress, is proposing to pay ASCs only 62% of the rates paid to HOPDs for the same surgical procedures. This payment rate is wholly inadequate and does not reflect a realistic differential between the costs incurred by hospitals and ASCs in providing the same services. In fact, the proposed payment rate may result in the Medicare program paying more for outpatient surgery because beneficiaries' only choice for many procedures will be the more costly hospital setting. Since infection rates are typically higher in the hospital setting than in the ASC setting, the proposed payment rate will also have the unintended consequence of reducing the quality of care for thousands of beneficiaries, as well.

Under current law, ASCs are to be provided no annual cost-of-living updates from 2004-2009, notwithstanding significant increases in the costs of delivering care. Commencing in 2010, CMS is proposing to pay ASCs an update equal to the consumer price index (CPI), while HOPDs would be paid an update based on the hospital market basket (HMB), which is typically higher. Such a two-tiered update scheme is unfair on its face and does not appropriately recognize the costs of providing care in the ASC setting. The new payment system should provide hospital market basket updates to both ASCs and HOPDs since both provide the same services and incur the same costs in delivering high-quality surgical care.

Lastly, the solutions proposed in the rule with regards to improving the case mix are not feasible for single specialty centers. CMS should also realize that the methodology used by Medicare is the primary payment indicator for other payers, removing any incentive for other insurers to pay ASCs appropriately.

We ask that CMS reverse the proposal and establish ASC reimbursement based on the costs of ASCs and not below that rate. For further information, please contact Jayna Bonfini at jbonfini@aad.org or 202-842-3555 or Norma Border at nborder@aad.org or 847-330-0230.

We thank you for the opportunity to comment on this proposed notice.

Sincerely,

Brett M. Coldiron MD

Brett Coldiron, MD, FAAD
Chairman, Health Care Financing Committee

Cc: Stephen P. Stone, MD, FAAD, President
Diane R. Baker, MD, FAAD, President-Elect
David M. Pariser, MD, FAAD, Secretary-Treasurer
W. Patrick Davey, MD, FAAD
Ronald A. Henrichs, CAE, Executive Director and CEO
John D. Barnes, Deputy Executive Director, AADA
Judy Magel, PhD, Senior Director, Practice, Science & Research
Laura Saul Edwards, Director, Federal Affairs
Cyndi Del Boccio, Director, Executive Office
Jayna Bonfini, Assistant Director, Federal Affairs
Norma Border, Senior Manager, Coding and Reimbursement

Submitter : Mr. Harvey King **Date:** 11/05/2006

Organization : Mr. Harvey King

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a hemodialysis patient (1-1/2 years now). I approve of anything which will make conditions easier and better. Don't know what else I can say. Thank you for the oportunity to be heard.

Harvey S. King

Submitter : **Dr. Peter Loeb** **Date: 11/05/2006**

Organization : **Dallas Endoscopy and Dallas Digestive Disease Ass.**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

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;

My name is Peter M. Loeb, a physican and gastroenterologist at Dallas Endoscopy Center in Dallas, Texas. Our ambulatory surgery center offers endoscopy services and has been providing high quality, patient centered, and cost effective interventional procedures and surgery since 2005

CMS now reimburses the hospital for a diagnostic colonoscopy done in our hospital outpatient surgery setting $542.53 and they reimburse ASC's $446.00. CMS are proposing a cut ASC payments to $349.82 for a colonoscopy (approximately $100.00).

In our relative small center, we perform nearly 3000 Medicare procedures per year. The extra cost of our center would be nearly $300,000. The cost for Medicare will be greater that 1,000,000 times greater if one considers that every Medicare patient should have a least one colonoscopy and 10-20% will require more than one.

This proposal is being considered at a time when fewer surgeons and gastroenterologist are participating because of drastic decreases in Medicare reimbursements to physicians, and the costs for colon preps, endoscopy equipment, medical devices and drugs for Medicare patients are increasing.

These actions are transferring taxpayer money and business from the small businesses and individual physicians and placing them into large Corporations (Hospital Conglomerates, Drug Companies, Medical Device Companies) This will have the result of eventually eliminating the private individual physican and increasing the cost of medical care.

Please do all you can prevent this movement.
Thank you,

Peter M. Loeb M.D.

Gastroenterologist
Dallas Endoscopy Center
214-520-8235
214-520-8236 fax

Submitter : Mrs. Sarah Martin **Date:** 11/05/2006

Organization : Symbion Healthcare, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I would like to see the rates of reimburesement increased to the proposed rate of 75% of HOPD rates. ASC's provide the exact same procedure to the patient as the hospital ASC does and we need to eliminate the descrepancy in payment for these procedures. Additionally, ASCs are able to provide this care with improved quality of care, with minimal infection rates, returns to surgery or admissions to the hospital. This translates into less dollars spent by CMS on patient care.

ASC Unlisted Procedures

ASC Unlisted Procedures

I would prefer to see an exclusionary list of procedures, that continue with a list of procedures that are unable to be performed in the ASC setting. ASCs are able to perform more complex procedures, without any decrease in the quality of care to the patient. The patient deserves to have the right to access this care available in the ASC setting.

Submitter : **Dr. Joseph Mouhanna** **Date: 11/05/2006**

Organization : **Miami Pain**

Category : **Physician**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

November 5th, 2006

Leslie V. Norwalk, Esq., Acting Administrator
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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 and ASCs, and subsequently 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,

Joseph E. Mouhanna, MD

Submitter : **Mr. Edward Rivero** **Date: 11/05/2006**

Organization : **Miami Pain**

Category : **Physician Assistant**

Issue Areas/Comments

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November 5th, 2006

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Dear Ms. Norwalk:

As a practicing interventional pain physician assistant, I am disappointed at CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals and ASCs, and subsequently 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.

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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,

Edawrd Rivero, DC, PA-C