



173

## HEALTHSOUTH<sup>®</sup>

October 26, 2006

Leslie V. Norwalk, Esq., Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS - 4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

Dear Administrator Norwalk:

I am writing to share my concerns regarding the Medicare Ambulatory Surgical Center (ASC) payment system and ASC list reform. Although I am encouraged by the department's efforts to reform the ASC payment system and align more closely to the hospital outpatient department (HOPD) payment system, I feel as if there are several shortcomings included in the proposal.

As I am sure you are aware ASCs provide patients with a high-quality, convenient and less expensive option for their outpatient surgery. When Medicare patients choose to have their outpatient surgery performed at an ASC, the patient and Medicare saves money. While I am acutely aware that the proposed payment plan must be budget neutral, I believe the proposed 62% of HOPD rates is low and a budget neutral percentage could be substantially higher than this proposal.

The proposal includes a list of ASC approved procedures. Although this list does add 750 new procedures to the ASC list, it is still limiting the procedures that can be performed in an ASC as compared to an HOPD. I believe we should maximize the choices for beneficiaries by expanding the list to include all procedures that can be performed in a HOPD. After all if a procedure is deemed safe to perform in an HOPD it is safe to perform in an ASC. The only difference I see is the cost savings related to the use of an ASC versus HOPD.

HOPDs are allowed market basket updates on their pricing. The proposed ASC payment system limits the ASCs to consumer price index updates. As I am sure you are aware, the difference in these two inflation rates is a full percentage differential each year. Knowing that ASCs face the same inflationary pressures as HOPDs, including nursing costs and medical goods, it seems the pricing updates should be reflective of this pattern.

I am hopeful your department will consider all of the above points when making a final proposal for ASC payment reform. As stated above, ASCs provide an excellent cost

savings opportunity for all involved. The cases being performed in HOPDs are all appropriate for the ASC setting and are already being performed on patients covered by other payers. This proposal has the potential to upgrade the services available to Medicare patients and create exponential savings.

Respectfully,

A handwritten signature in cursive script that reads "Holly C. Ramey". The signature is written in black ink and is positioned above the printed name.

Holly C. Ramey  
Vice President of Operations  
HealthSouth Corporation

Center for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4125-P  
PO Box 8011  
Baltimore, MD 21244-1850

November 1, 2006

To Whom It May Concern:

I am writing to voice my concerns regarding the proposed CMS changes for outpatient surgery centers. I am a registered nurse and have been an administrator of a surgery center for more than twelve years. I am concerned about the impact these changes will have on the patients, outpatient surgery centers and our local area hospitals.

Without reimbursement that at least covers the costs of the procedures there will be fewer surgery centers performing these procedures. What will happen to the elderly patients who need these services if they are eliminated from the surgery centers because we can't afford to do them? Where will these services be provided? In our local area hospitals and across the state of California there is such a severe nursing shortage it is inconceivable that this case volume can be shifted back to the outpatient department of the hospital with out creating a huge back log of patients and adding to an already over burdened hospital system. I am not sure if CMS is aware but in my area, nursing costs have increased by double digits in the last year. I understand you are trying to balance the budget and keep healthcare costs in line. We want to help you achieve this as well. However the supply costs and the nursing costs are the same regardless of where the surgery is performed. The outpatient surgery centers should be given increases based on the same market update as the hospitals.

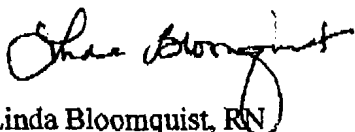
CMS's proposal to continue with the list of approved Medicare procedures is very frustrating. Many of the unapproved procedures are safe and less expensive if performed in the surgery center setting. We screen all of our patients to be sure they meet the criteria to be admitted to the surgery center. If outpatient surgery centers were allowed to perform procedures such as Laparoscopic Cholecystectomies for CMS patients, this alone would decrease Medicare's costs of care and give your patients a broader access to care.

# **HEALTHSOUTH**

Physicians Plaza Surgery Center

We are not asking for equal payment, but fair payment, increases based on the same parameters and reconsideration of the Medicare approved procedure list. All these things will help to achieve the common goal of a neutral budget. If you would like to speak to me please phone me at 661-322-4744.

Sincerely,



Linda Bloomquist, RN  
Administrator  
Healthsouth Physicians Plaza Surgical Center  
6000 Physicians Plaza  
Bakersfield, California 93301

**HEALTHSOUTH**  
Surgery Center-Fort Sutter

175

November 2, 2006

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attn: CMS-4125-P  
PO Box 8011  
Baltimore, MD 21244-1850

**Subject: Medicare Modernization Act and the CMS Proposed Rule**

I represent Fort Sutter Surgery Center, a large multi-specialty surgery center in Northern CA. The center performs over 500 cases per month and serves a necessary need in the community for services that can be provided on an outpatient basis. We provide high quality care in a convenient, friendly setting that is less threatening than the hospital environment. We get patient compliments frequently on how much they prefer this environment over the large hospital system when receiving care. When Medicare beneficiaries chose Fort Sutter Surgery Center for their outpatient surgical care, they, as well as Medicare save money. This appears to be a win-win situation for both Medicare and its beneficiaries.

CMS can continue to support Medicare patients, as well as save Medicare money, by making ambulatory surgery centers (ASC) a competitive alternative to outpatient care provided in the hospital setting. The six year payment freeze to surgery centers and the cuts in the Deficit Reduction Act has resulted in much reduced payments to ASCs in relation to payments made when services are provided in the hospital outpatient department (HOPD). During this time, HOPDs have received significant payment increases.

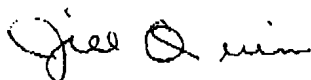
In the CMS proposal, CMS estimates that surgery centers should be paid only 62% of HOPD rates for providing identical outpatient services. That reduced payment rate will result in significant cuts to a number of commonly performed services in surgery centers. For example, Fort Sutter Surgery Center performs a large number of GI procedures and cataract surgery, which results in about 30 percent of the center's volume. The disparity between HOPD rates and ASC rates should not be widened. Surgery centers are challenged by the same fiscal issues as hospitals in relation to hiring and retaining qualified RNs, the cost of medical supplies, implants, and all other inflationary pressures.

The CMS proposal for updating ASC payments by the CPI rather than the hospital market basket update is not equitable. This will result in a full percentage differential

every year. Over time, this disparity in payments will create deeper divisions between prices paid to HOPDs and ASCs without any evidence that different payment rates are warranted. The patient is receiving the identical service at either the HOPD or the ASC.

It is my opinion that the CMS proposed rule continues to treat OPHD and ASCs differently in some areas. These differences should be eliminated and ASC and OPHD payments should be made on the same basis. If this does not occur, many procedures, including those GI and cataract surgeries performed at this surgery center, will not be performed because CMS payments will be below the cost of performing those procedures. In the long run, this will cost the CMS additional funds to provide the same services. Additionally, Medicare beneficiaries will lose the convenient, cost effective care that surgery centers are known to provide.

Sincerely,



Jill Quimm, RN, BSN, EMBA  
Administrator

**HEALTHSOUTH**  
Surgery Center of Atlanta

176

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS - 4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

Dear Administrator Norwalk:

I am writing with regards to the Medicare Ambulatory Surgical Center (ASC) payment system and ASC list reform. Let me add that I am a twenty year RN veteran of the HOPD system and have had opportunities to evaluate the merits of both systems. Although I am encouraged by the department's efforts to reform the ASC payment system and align more closely to the hospital outpatient department (HOPD) payment system, I believe there are many opportunities to improve the ASC payment system to assist the beneficiaries.

ASCs provide patients with a high-quality, convenient and less expensive option for their outpatient surgery. As a twenty year veteran of the hospital based system, I can concur that the ASC setting is of the same quality, yet less expensive and more convenient. Outpatient surgery performed at an ASC, the patient and Medicare saves money. While I am acutely aware that the proposed payment plan must be budget neutral, I believe the proposed 62% of HOPD rates is low and a budget neutral percentage could be substantially higher than this proposal.

The proposal includes a list of ASC approved procedures. The list does add 750 new procedures to the ASC list, it is still limiting the procedures that can be performed in an ASC as compared to an HOPD. I believe we should maximize the choices for beneficiaries by expanding the list to include all procedures that can be performed in a HOPD. After all if a procedure is deemed safe to perform in an HOPD it is safe to perform in an ASC. Again, the only real difference is the cost savings and ease of

business at an ASC. Especially our senior population is less intimidated by the ASC setting.

HOPDs are allowed market basket updates on their pricing. The proposed ASC payment system limits the ASCs to consumer price index updates. As I am sure you are aware, the difference in these two inflation rates is a full percentage differential each year. Knowing that ASCs face the same inflationary pressures as HOPDs, including nursing costs and medical goods, it seems the pricing updates should be reflective of this pattern.

I am hopeful your department will consider all of the above points when making a final proposal for ASC payment reform. As stated above, ASCs provide an excellent cost savings opportunity for all involved. The cases being performed in HOPDs are all appropriate for the ASC setting and are already being performed on patients covered by other payers. This proposal has the potential to upgrade the services available to Medicare patients and create exponential savings.

Respectively,



Deborah T. Brown, RN MBA  
Perimeter Surgery Center of Atlanta



177

**HEALTHSOUTH**  
Surgery Center of Charlotte

NOV/03/2006/FRI 03:40 PM

HEALTH-SOUTH

FAX No. 704 358 8267

P. 002

November 3, 2006

Centers for Medicare & Medicaid Services  
Department of Health and Human Resources  
Attn: CMS-4125-P  
Mail Stop CA-26-5  
7500 Security Boulevard  
Baltimore, MD. 21244-1850

RE: CMS Proposed Rule on new ASC payment system

Dear Sirs:

I would like to state my opinion regarding the CMS proposed rule on the new ASC payment system. As an administrator in an ambulatory surgery center, I do feel that ASCs provide patients with a less expensive and at the same time high quality option for their outpatient surgery. Choosing an ASC saves patients and Medicare money.

ASCs have been operating under a six year payment freeze while outpatient hospital departments have been receiving significant payment increases. The proposed rule will further reduce our payments for the identical surgical services.

CMS can aid Medicare and its beneficiaries in saving money by making ASCs a competitive alternative to outpatient hospitals. Only ASCs are bound to a list of permitted procedures that can be performed in an ASC setting. The list needs to be expanded in order to increase patient choice. There have been efforts made to increase the ASC list, however, most of the new procedures are of low complexity and are capped at the physician fee

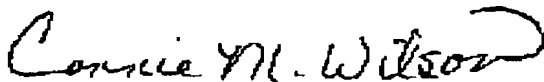
**HEALTHSOUTH**  
Surgery Center of Charlotte

schedule rate. For years, higher complexity services have been safely and efficiently performed in the ASC setting throughout the country.

ASCs and hospital outpatient surgery payments should be made on the same basis. Implantable DME are bundled into hospital outpatient payments that allow a full recovery of the DME costs. Payments to ASCs for implantable DME should be set to allow full reimbursement for DME costs.

There is no evidence that different payment systems are warranted or necessary. I would ask that CMS will allow ASCs to become a vital and viable competitive alternative to more expensive outpatient hospital departments.

Very truly yours,



Connie M. Wilson, RN, BSN, CNOR  
Administrator

NOV/03/2006/FRI 03:40 PM

HEALTH-SOUTH

FAX No. 704 358 8267

P. 003

04:19 AM

P. 02/03

**HEALTHSOUTH**  
Mobile Surgery Center

178

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4125-P  
P. O. Box 8011  
Baltimore, MD 21244-1850

Dear Administrator Norwalk:

As an Administrator of a free standing surgery facility I am writing to voice my concerns regarding the Medicare Ambulatory Surgical Center (ASC) payment system and ASC reform list. Being of a clinical background and having been fortunate enough to work as a surgical nurse in a hospital as well as an ASC, I can certainly say without doubt that we perform a vital service to the community. We can, and do, perform procedures that are done daily in the hospital setting and we can do these at a much lower cost to the Medicare program as well as the patient while still providing EXCELLENT outcomes.

I am asking you to look at the list of ASC approved procedures in comparison to the HOPD list and expand our list in order that we are directly aligned with the HOPD list. We are currently doing many of these procedures for other payers with excellent outcomes and as I have mentioned above while doing this we are providing a lower -cost alternative to the HOPD setting resulting in a savings to the Medicare program as well as their beneficiaries.

I understand that the new ASC payment system must be budget neutral however I hope that CMS will create a greater balance between rates paid to HOPD's and ASC's for the same service. Again, the ASC is constantly looking for ways to streamline day to day operations to provide a low cost environment along with excellence in health care. However, we continue to struggle simply due to the increases in the cost of healthcare as well as basic cost of living increases. These factors continue to make us work smarter and more efficiently each day. Our employees take personal ownership in striving for this as they realize that this directly affects our bottom line and their paycheck. Having this type of environment at an ASC is vital to the service that we perform each and every day.

Julie C.  
Administrator  
HealthSouth

**HEALTHSOUTH**  
Mobile Surgery Center

178

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4125-P  
P. O. Box 8011  
Baltimore, MD 21244-1850

Dear Administrator Norwalk:

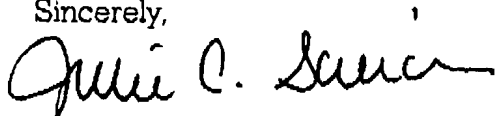
As an Administrator of a free standing surgery facility I am writing to voice my concerns regarding the Medicare Ambulatory Surgical Center (ASC) payment system and ASC reform list. Being of a clinical background and having been fortunate enough to work as a surgical nurse in a hospital as well as an ASC, I can certainly say without doubt that we perform a vital service to the community. We can, and do, perform procedures that are done daily in the hospital setting and we can do these at a much lower cost to the Medicare program as well as the patient while still providing EXCELLENT outcomes.

I am asking you to look at the list of ASC approved procedures in comparison to the HOPD list and expand our list in order that we are directly aligned with the HOPD list. We are currently doing many of these procedures for other payers with excellent outcomes and as I have mentioned above while doing this we are providing a lower -cost alternative to the HOPD setting resulting in a savings to the Medicare program as well as their beneficiaries.

I understand that the new ASC payment system must be budget neutral however I hope that CMS will create a greater balance between rates paid to HOPD's and ASC's for the same service. Again, the ASC is constantly looking for ways to streamline day to day operations to provide a low cost environment along with excellence in health care. However, we continue to struggle simply due to the increases in the cost of healthcare as well as basic cost of living increases. These factors continue to make us work smarter and more efficiently each day. Our employees take personal ownership in striving for this as they realize that this directly affects our bottom line and their paycheck. Having this type of environment at an ASC is vital to the service that we perform each and every day.

I appreciate the opportunity to share my views on this very important matter. I am extremely hopeful that your department will consider all of the above when considering the final proposal for ASC reform.

Sincerely,

A handwritten signature in black ink that reads "Julie C. Saucier". The signature is written in a cursive style with a large, prominent "J" and "S".

Julie C. Saucier RN,BSN  
Administrator  
HealthSouth Mobile Surgery Center



One HealthSouth Parkway  
Birmingham, AL 35243

179

November 6, 2006

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
ATTENTION: CMS – 4125-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
335 Russell Senate Office Building  
Washington, DC 20510

Subject: CMS proposed rule restricts Medicare recipients to receive cost effective quality care in ambulatory surgery centers.

I serve as the Director of Clinical Resources and Education with Healthsouth Corporation's ambulatory surgery division of over 150 ambulatory surgery centers across the country. We employ over 4,000 healthcare workers who provide expert quality healthcare to over 500,000 patients a year, with a high number being Medicare recipients. I am writing to share with you my concerns about how this CMS proposed rule will restrict patient's ability to choose where to go for healthcare services. Medicare patients are not the only healthcare consumers who can benefit from quality healthcare services in a cost effective manner in the ambulatory surgery center setting. I am concerned about the result of limited access to care that this ruling would impose upon health care providers and Medicare patients.

The proposed restrictions continue to treat Hospital Outpatient Departments (HOPD) and ambulatory surgery centers (ASC) differently in certain key respects regarding payment and reimbursement. These differences should be eliminated because ASC's face the same inflationary pressures and cost of care challenges as HOPD's, including challenges with hiring and retaining qualified and experienced nurses and technicians. Providers are already trying to absorb the effects of Medicare reductions included in the deficit reduction legislation already enacted. ASC payments should be Basing ASC payment on the hospital market basket update instead of the consumer price index will eventually result in payment disparities between HOPDs and ASCs. We agree that care must be delivered efficiently, but asking providers to continue to absorb higher wage and supply costs without any reference to differences in quality of care is not fair for ambulatory surgery centers. Before any new rules are adopted, we urge the enactment of reforms that will tie payments more closely to the quality of services delivered to Medicare patients in the ambulatory surgery center setting.

We believe that a broader plan based on pay-for-performance is needed to address the long term challenges facing the Medicare program and know that the ambulatory surgery centers are positioned in today's healthcare market to succeed in these areas. For example, our surgery division has received high patient satisfaction scores, revealing that our surgery centers have consistently performed above national benchmarks as a whole with patient satisfaction and overall quality of care. An example of some of the procedures that can be performed in an ambulatory surgery center, safely, in a cost efficient manner, with out sacrificing quality, are cataract surgeries, orthopedic procedures requiring implant reconstruction, and pain management procedures. The aging population, facing such healthcare needs, can receive quality care in a safe, cost effective manner for cataract extractions, pain management procedures, orthopedic procedures requiring implants and reconstruction in our surgery centers. Such patients can be admitted and safely discharged to their



One HealthSouth Parkway  
Birmingham, AL 35243

homes the same day following specific criteria to ensure safe patient outcomes. This is possible because the surgery center setting employs teams of experienced, skilled and qualified healthcare providers, working together to provide uninterrupted care from preoperative preparation, through the intraoperative process, and then through the postoperative plan of care.

Providing quality healthcare services in a patient centered environment focused on safety, efficiency, and cost effectiveness has proven to meet the needs of our patients. Yet, we face increasing challenges of elevated procedures costs, such as is the case with implants. How can our surgery centers be expected to perform implant procedures when implants will be reimbursed at less than 2/3 of the HOPD rate? We are providing same levels of care for outpatient procedures as the hospital outpatient surgery departments but they are receiving higher payments for implant procedures.

I respectfully urge you to carefully consider the financial impact of the CMS proposed rule budget proposals on healthcare providers and our patients. Thank you for your consideration of this important matter regarding the CMS proposed rule as it will restrict Medicare patients from choosing quality healthcare in a cost effective manner in the ambulatory surgery center setting.

Respectfully,

Lee Anne Blackwell, RN, BSN, EMBA, CNOR

A handwritten signature in cursive script that reads "Lee Anne Blackwell, RN".

Healthsouth Corporation Ambulatory Surgery Division  
One Healthsouth Parkway  
Birmingham, AL 35243

180

October 24, 2006

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear Sirs:

I am writing today to express my concerns regarding the proposed payment system that the Medicare Modernization Act requires CMS to put in place by 2008. In the first quarter of this year, I sat on a healthcare panel with President Bush to discuss transparency in healthcare. As I indicated to President Bush at that time, it was my hope that this new payment system would provide an opportunity to provide more transparency across sites of service and permit ASCs to be a vital and viable competitive alternative to more expensive outpatient hospital departments. I believe however, that the new system that CMS has proposed has missed that opportunity.

In my position, I am responsible for 12 Ambulatory Surgery Centers in the northeast region. These ambulatory surgery centers provide patients with a high-quality, convenient and less expensive option for their outpatient surgery. When Medicare beneficiaries choose our ASCs for their outpatient surgery over the more costly hospital setting, both they and Medicare save money.

I would strongly support MedPAC's suggestion to move ASCs to the hospital outpatient prospective payment system (HOPPS) only if the proposed rule would consistently tie ASCs payments to the HOPPS. But it does not do so in many respects. Let me explain.

ASCs confront the same inflationary pressures as hospitals – hiring and retaining qualified clinical staff, purchasing medical supplies and the like. But ASCs have been in a six year payment freeze and as a result of this, coupled with the cuts in the Deficit Reduction Act, ASCs get much lower payments relative to payments made when identical services are provided in the HOPD. Over the past years, HOPDs have received significant payment updates while ASC payments remain frozen. In the proposed payment system, CMS will update ASC payments by the consumer price index, a general measure of inflation of the economy rather than the actual higher costs associated with a hospital market basket update. This will result in a full percentage differential each year. Over time, the disparity in payments will create deeper divisions between prices paid in the HOPD and the ASC without any evidence that different payment rates are warranted. This will



also have the unintended consequence of higher co-pays and out of pocket cash for Medicare beneficiaries who use the hospital setting.

CMS could help Medicare and beneficiaries save money by making ASCs a viable, competitive alternative to outpatient hospitals. But in the proposed rule, CMS estimates that ASCs should only be paid 62% of HOPD for providing the identical outpatient surgical services. That low payment rate will result in significant cuts to a number of important, commonly performed services in ASCs including GI and ophthalmology. While payments for other specialties such as orthopedics will rise, it is not clear whether they will increase enough to make them viable procedures to be provided in ASCs. The two payments are not calculated in a similar manner. For example, prosthetic devices and implantable DME are bundled in HOPD payments at rates that allow a full pass through of the DME costs; ASC payments do not. Payment levels for ASCs should be set at similar levels to allow full reimbursement for DME costs (*i.e.*, whatever discount factor is used to determine ASC payments relative to HOPD should not apply to the portion of the payment related to DME cost). Otherwise, many procedures that could be safely performed in an ASC more conveniently for patients and at less cost to the Medicare program will not be available because payments will remain below cost. The system, as proposed is not parallel to HOPD and could lead to reduced healthcare service access to Medicare beneficiaries.

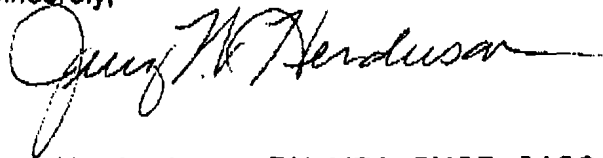
Another problem with the proposed rule is the interpretation of "budget neutrality" required in the legislation. CMS should adopt an expansive, realistic interpretation of budget neutrality that examines total Medicare spending on outpatient surgery. It is clear that the new payment system and the expansion 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 HOPD.

In December 2005, Secretary Leavitt wrote a letter to Senator Crapo that HHS intends to "maximize choices" for beneficiaries by significantly expanding the list of procedures that could be performed in an ASC. I agree with MedPAC and Secretary Leavitt that CMS should create an exclusionary list for ASC services instead of an approved procedure list. However, CMS continues to use arbitrary and ambiguous criteria to approve ASC procedures. Of the many payment systems administered through CMS, only the ASCs are bound to a list of permitted procedures determined by CMS. While the proposed rule would add 750 procedures to the ASC list, most of these are low complexity procedures and are capped at the physician fee schedule rate, not paid using a percentage of HOPD rates. Some rates do not even cover the costs of creating the required paper work associated with creating and maintaining a medical chart and billing much less the cost of providing the service. On the other hand, CMS failed to include on the list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. For example,

the laparoscopic cholecystectomy procedure is not included on the approved list, yet the first time that this procedure was ever performed it was in an ASC and it continues to be safely performed every day in ASCs for patients with other payment sources. By not creating a truly exclusionary list, as opposed to an approved procedure list, CMS limiting beneficiary access and is losing an opportunity to increase patient choice and the ability to rely on the clinical judgment of the surgeon for the patient's best interest.

I continue to be committed to the goal of lowering the cost of health care while maintaining high quality and safety for our patients. I believe that a payment system that rewards providers for adherence to these goals instead of punishing them for their efforts would better serve both beneficiaries and the Medicare program. Over the past 30 years, ASCs have set the standard for cost effective patient care and should be preserved as a low cost alternative for surgical needs. We only ask to be treated fairly so that we can continue to serve. Thank you in advance for considering my comments regarding the proposed payment system.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jerry W. Henderson". The signature is written in black ink and is positioned below the word "Sincerely,".

Jerry W. Henderson, RN, MBA, CNOR, CASC

# HEALTHSOUTH

Surgery Center of Colorado Springs

181

Leslie V. Norwalk, Esq., Acting Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-1506-P  
Room 445-G  
Hubert 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:

Thank you for taking the time to read my letter today. My name is Gina Lovejoy and I am the Administrator of the first ASC built in Colorado Springs, CO. Colorado Springs Surgery Center was built in 1991 and is still going strong today 15 years later. We are 91.5% corporate owned and only 8.5% physician owned at this time. Colorado Springs Surgery Center does about 250 – 300 cases per monthly. Our case mix is dominated by GI (100) and Pain cases (60), followed by podiatry, gynecology, and plastic surgeries.

We have 30 employees that work here, many having been here since the center's inception. These experienced, tenured staffers provide patients the highest quality ambulatory surgical care in our community. The physicians that utilize this facility agree that our service is second to none. This is the reason for my letter. I am deeply concerned about the CMS proposed ASC rate changes, the payment inequities that they represent, and the negative effects such rate will have on the financial health of our high efficiency ASCs.

*80% of all surgical procedures performed today are cases that can be safely and more cost effectively performed in an outpatient surgery setting. The patients leave more satisfied with the care they receive and the government can curtail the meteoric rise in healthcare costs. It makes good practical sense that we should not be penalizing the providers of such high quality, cost effective services!*

I commend the CMS for their painstaking efforts in preparing the proposed changes as there have been no significant changes in ASC payments in over 10 years. The industry has proven that it can deliver premium surgical services at costs that are far less than hospitals. The ASCs around the U.S. should be rewarded and applauded for these accomplishments of savings rather than penalized as would be the net effect of the full implementation of the 2008 rates. The proposed 62% of HOPD rates will encourage the movement of certain cases to the hospitals, costing Medicare and its' beneficiaries more money. Why would we move in this direction? This seems to fly in the face of your agency's fiduciary responsibilities to the taxpayers and beneficiaries alike.

**HEALTHSOUTH**

Surgery Center of Colorado Springs

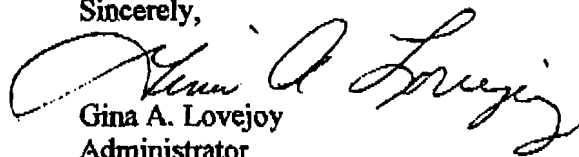
**I would request the CMS consider the sensible alignment of ASC and HOPD payment policies.** Aligning the payment systems for ASCs and the hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. These benefits should be maximized to the greatest extent allowed by the law. Many policies that were extended for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, ultimately costing taxpayers and beneficiaries more than necessary.

To this end, please review the following revisions to be considered for further refinement:

- 1) The procedure list – excludes many procedures appropriate for ASC setting
- 2) Treatment of unlisted codes – ASCs should also be eligible for unlisted payments
- 3) Different payment bundles – to be same as HOPD
- 4) Different measures of inflation – to be same as HOPD
- 5) Cap on office-based payments – should be omitted
- 6) Secondary rescaling of rates – be consistent with HOPD adjustments
- 7) Non-application of HOPD policies to ASC
- 8) Use of different billing system – use UB-92 for consistency

Thank you for your hard work on these issues and your reconsideration of the proposed payment rate system. I believe that to serve the Medicare beneficiaries and our government in the most favorable manner, the proposed changes you have put forward must be modified. Please contact me if I may offer you, as a facility Administrator, any further insight into this urgent matter.

Sincerely,



Gina A. Lovejoy  
Administrator

Colorado Springs Surgery Center  
1615 Medical Center Point  
Colorado Springs, CO 80907  
(719) 635-7740

# Ft. Worth Surgery Center

A HEALTHSOUTH SURGERY CENTER

182

October 30, 2006

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear Center for Medicare and Medicaid,

RE: CMS Proposed Rule for Ambulatory Surgery Centers.

This letter is to request consideration of our comments regarding the current CMS Proposed Rule for Ambulatory Surgery Centers. This facility serves approximately 7500 patients per year and employs approximately 75 health professionals. Ambulatory Surgery Centers provide a safe, convenient, and cost effective alternative to the Hospital Outpatient Departments. Listed below are several issues we would like you to consider.

First, we are requesting reimbursement for Ambulatory Surgery Centers to reflect or remain close to the Hospital Outpatient Department rates. While we offer safe, convenient, and cost effective care, our staffing and supply expenses remain consistent with the Hospital Outpatient Departments and the proposed reimbursement of 62% of Hospital Outpatient Department rates would certainly jeopardize our existence. We urge you to narrow the proposed 62% gap.

Next, we believe the proposed list of the additional 750 procedures should be reimbursed at a competitive rate consistent with Hospital Outpatient Departments. Many of these proposed procedures are covered in a physician's office and physicians bring these cases to the Ambulatory Surgery Centers for safety reasons which necessitate a higher level of healthcare. These procedures incur additional expenses and should be reimbursed accordingly not at the capped physician fee schedule rate.

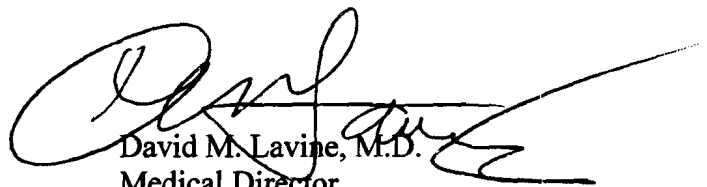
Overall we are requesting a reimbursement program parallel to the Hospital Out patient Departments in all areas of the CMS proposed rule. We ask for your support and consideration as the reimbursement reform moves forward. We believe we provide a safe, convenient, cost effective alternative to the Hospital Outpatient Department for our patients, staff, and physicians.

Thank you in advance for your consideration to these issues.

Sincerely,



Peggy Rhoads, RN  
Administrator  
Healthsouth Fort Worth Surgery Center



David M. Lavine, M.D.  
Medical Director  
Healthsouth Fort Worth Surgery Center

Remember our discussion in Orlando that even though it is hard to make the case that any one letter is going to make a difference with CMS, a hundred letters from HealthSouth ASCs and a thousand letters from other ASCs and physicians could certainly do so. Even though the ASC Coalition is going to prepare a very long and detailed set of comments on the proposal, it is important that CMS understand that the concerns outlined in the attachment are shared by ASCs and physicians around the country. In matters like this, volume of comments – so long as they are not simply duplicates of a form letter – really do matter. Therefore I ask that you take a few hours over the next week to discuss the matter with our physician partners and to compose a letter to CMS.

The letter (an original and two copies) should be addressed to:

*(For regular mail)*

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

*(For express or overnight mail)*

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Letters must be received by CMS no later than 5:00 pm Monday, November 6. Letters sent by regular mail should be postmarked no later than the October 31<sup>st</sup> in order to ensure actual delivery before the deadline. Another option would be to fax a copy of your comments to Justin Hunter in our Washington, D.C. office at 202-756-3333. Justin can arrange for them to be hand-delivered to CMS on or before the 6<sup>th</sup>.

Please keep copies of your letters for your files. We will likely ask you to forward them to your local Members of Congress later this year in order to build Congressional interest in the issue. However, please wait for further instruction on this so that the effort can be coordinated with other members of the larger ASC Coalition.

If you have questions about the CMS proposal, any of the talking points on the attachment, or wish to discuss the content of a letter, please do not hesitate to call me at 205-970-4500 or Justin at 202-756-3466.

Thank you for help on this. I hope that we can count on each of our ASCs to deliver a letter to CMS on this proposal.

Attachment

cc: Mike Snow  
John Markus  
Justin Hunter



## REHABILITATION MEDICAL GROUP, P.A.

183

November 2, 2006

Centers for Medicare & Medicaid Services  
Department of Health Care Services  
Attention: CMS-1506-P or CMS-4125-P  
Post Office Box 8011  
Mail Stop C4-26-05-7500  
Security Boulevard  
Baltimore, Maryland 21244-1850

To Whom It May Concern:

I am writing on behalf of the CMS proposed rule (Revised Payment System for Ambulatory Surgical Centers) scheduled for implementation on January 1, 2008. It has come to my attention that the proposed rule, as published by the Centers for Medicare & Medicaid Services, would result in proposed changes to the ASC payment system. I disagree with the changes that are being made as I do not feel that they adequately reflect the costs incurred in ambulatory care settings and feel that this change should not be implemented.

It is my assessment that it is inaccurate to assume that ASC costs are an average of 38 percent less than hospital outpatient departments, especially in the case of high-cost implantable devices. One of the most important shortcomings in the hospital outpatient payment methodology is the known phenomenon of charge compression. It underestimates the cost of more expensive items, such as medical devices, resulting in payment rates that do not reflect true cost. CMS should remedy this issue by apply a decompression factor or other methodology, rather than allowing inaccurate rates to be carried over to the revised ASC payment system.

The proposed transition payments appear to include errors in the calculations for implantable devices, for which separate payment has historically been made. Device costs appear to have been inadvertently omitted from the calculations. The proposed payment methodology will inappropriately impact sites and service decisions. These decisions should be based on clinical considerations. Payment accuracy should be included at the goal of any new payment system to avoid service decisions based on financial factors, rather than clinical appropriateness. These payment issues will impede the transitional procedures associated with devices or other technology in the ASC setting when appropriate and will limit a beneficiary access to the needed procedures because ASCs will not receive adequate payment to cover their costs.

November 2, 2006

Payment amounts of implantable medical devices should be equivalent in both the hospital outpatient and ASC settings as acquisition costs for the devices does not vary between these facility types. Based on these findings, I feel that the ASC centers should receive full reimbursement as it relates to implantable devices and procedures related to pain management.

Again, I feel that the proposed changes are not appropriate for the reasons stated above. It is my impression that the proposed rule change for the revised payment system for ambulatory surgical centers should not be implemented and should be further discussed and revised to allow fair and equitable reimbursement for these centers.

Should you have any further questions or require additional information, please feel free to call me.

Sincerely,



Michael J. Creamer, DO

MJC/cjc



# PACIFIC COAST PAIN MANAGEMENT CENTER

November 1, 2006

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1506-P or CMS-4125-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Standiford Helm II, M.D., M.B.A.**  
Diplomate of the American Board of Anesthesiology  
with subspecialty certification in Pain Medicine  
Fellow of Interventional Pain Practice  
Qualified Medical Evaluator

**Christine E. Giddings, PA-C**

184

Re: Proposed changes for ASC regulation for CY 2008/2009

Dear Sir or Madam:

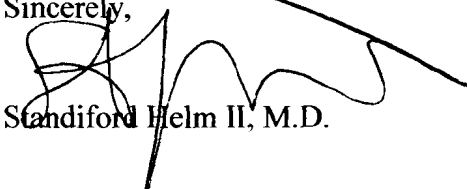
I am writing because of my concern that the proposed regulations regarding reimbursement for procedures done in ambulatory surgery centers will harm our growing Medicare population. I practice interventional pain management. A large part of my practice deals with the effects of spinal degeneration, the wear and tear that comes with aging, upon the functionality of our aging citizens. Many of these patients are able to maintain functionality because of the injections which we provide. I almost uniformly perform these procedures in the ASC setting, so that the proposed regulations will have a direct impact on my ability to care for Medicare patients.

CMS has proposed reimbursing ASCs at 62% of the HOPD rate. This conversion will lead to drastic cuts in reimbursement for ASCs. We then face the likelihood that ASCs will not allow these procedures to be done. At this point, either access will be lost or patients will be transferred to HOPDs, with increased cost to Medicare.

I believe that not enough time has been given to studying and evaluating the proposed methodology. The methodology which is implemented needs to be transparent and to accurately reflect the costs and benefits of using the ASC. I understand that CMS cannot, as an institution, ramp up a survey to be performed every five years, as mandated in by legislation. The proposed alternative, however, will create more problems than it resolves.

I respectfully request reconsideration of this methodology, with the development of an alternative approach which reflects the benefits of an ASC and which does not exclude the disabled and elderly from having procedures done at an ASC.

Sincerely,



Standiford Helm II, M.D.



185

November 2, 2006

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1506-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Sir / Madame:

We are writing in response to the proposed rule for ASC payment reform. While our surgical center applauds CMS for finally revamping the ASC payment system, the proposal falls significantly short of what is necessary to keep the ASC industry a viable option for Medicare beneficiaries. It also falls short in aligning the payment systems for ASCs and HOPDs in an effort to improve transparency.

The Deficit Reduction Act of 2005 requires CMS to reduce the payments to ASCs for any procedures for which the HOPD base payment rate is higher than the ASC rate. Why is there no concern regarding all the procedures that HOPDs are paid at a rate much higher than ASCs?? If CMS is truly concerned with the budget, why not encourage cases to go to ASCs where cost savings are real. More ASC cases and less HOPD cases would save CMS a substantial amount of money. The safe care of outpatients in ASCs has been well proven; therefore, the number of procedures must be expanded to include all surgical procedures that can be performed in an HOPD. The ASC fees need to be increased more than the proposed 62% of HOPD rates. Should ASCs buy only 62% of the supplies or equipment needed for a case or pay 62% of our nurses' salaries? The playing field must be leveled! There should be little difference in the payments for the exact same procedure being done in an ASC vs. an HOPD. What entitles HOPDs to 38% more reimbursement?? In addition to the disparity that the rates already create, HOPDs are able to be paid for implants/supplies and receive yearly rate increases. ASCs do provide charity care and have similar fixed costs as HOPDs. CMS LifeSafety codes for ASCs have become more stringent and require similar expenses to maintain patient safety.

The proposed inadequate reimbursement rate disparity will result in less procedures being done in an ASC; and therefore being directed to HOPDs. Instead of having the desired net result of budget neutral, CMS will be paying out more money to HOPDs than would have been paid previously. This rule will limit beneficiaries' access to ASCs.

Is it fair to limit the Medicare beneficiaries from cost effective safe care? We ask you to reconsider the overall outcome you are proposing.

Sincerely,

Debi Baker  
Co-Administrative Director /  
Patient Accounts Coordinator

Darlene Hinkle, RN, MSN, CNOR  
Co-Administrative Director /  
Director of Nursing

1826

Centers for Medicare /Medicaid Services  
CMS 1506-P  
Dept. of Health & Human Services  
Att: CMS-1506-P  
P.O. Box 8011  
Baltimore, Md. 21244-1850

Dear Colleagues:

I recently became aware of CMS's intent to pay ASC facilities at only 62% of Hospital rates for the same services. I have had an ASC since 1984 and deliver first quality care which my patients prefer to hospital services.

Our ASC has the same expenses for supplies, salaries and the ONLY difference a hospital has is an expense for emergency room. We need to purchase the same supplies and pay our staff commensurate salaries in order to provide the same or better service. We cannot survive on only 62% of hospital reimbursement. Although hospitals may have a better lobby the realities are we need AT LEAST 75% of the reimbursement for the same procedures. Also, Whatever final level of reimbursement is settled on it needs to be UNIFORM among all procedures performed, as, for example, my ASC just does Eye cases, and although some ASC's may be able to survive with a better payment for other procedures, those which are single specialty have no other procedures to subsidize them.

Please be sensible and realize that our costs are THE SAME for the services delivered and should be paid at the SAME rate as hospital. If, as a result of their superior lobbying there has to be a differential, we cannot survive with less than 75%.

Thank you for your consideration,

Sincerely,



Frank J. Grady, M.D., Ph.D. FACS  
103 Parking Way  
Lake Jackson, Tx. 77566

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

October 31, 2006

To Whom It May Concern:

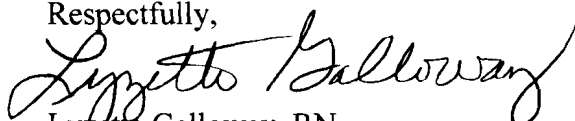
I am an employee of the HealthSouth Corporation and am writing you to request your close attention to the proposed rule changes for reimbursement for services in Ambulatory Surgery Centers.

As a Registered Nurse in an ASC for the past 23 years, I have witness thousands of patients who have safely received surgical care with excellent outcomes for procedures that were not included on an "allowed list" for the Medicare population. Now is the opportunity for this outdated system to change. I would like to encourage you to eliminate any exclusionary list that would not allow a Medicare beneficiary from having any outpatient procedure preformed in an ACS. This would allow the surgeon and the anesthesia department to assess the patient's risk factors and appropriateness for surgery in the ASC based on their overall health and medical conditions rather than their age and insurance coverage. In my opinion, there is no practical reason to allow a healthy, stable Medicare patient to receive outpatient services in a HOPD and not an ASC. Individual medical conditions and risk factors, as assessed by the physician, should dictate the setting.

In 2003, I became involved with the business aspect of the ASC industry. I must tell you, it has been quite a shock to discover the complexity of the healthcare reimbursement world. One of the most outstanding concerns is with the payment for implantable devices. While we all are aware that Medicare reimbursement may never be significantly profitable for the ASC industry, we cannot and should be expected to provide a service at a financial loss. This is exactly where we currently stand with regard to many procedures that require implantable devices. Your very close attention to this aspect of the proposed rule change is imperative. Otherwise, numerous procedures that could be safely performed in an ASC at a less cost to the Medicare program will not be available because payments will remain below cost.

Thank you for your time and consideration.

Respectfully,

  
Lyzette Galloway, RN  
Administrator

**EASTERN PENNSYLVANIA ENDOSCOPY CENTER  
1611 POND ROAD, SUITE 103  
ALLENTOWN, PA 18104  
PHONE: 610-289-2172 FAX: 610-289-2542**

November 1, 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, D.C. 20201

Re: Medicare Program: Ambulatory Surgery Centers PPS Proposed Rule

Dear Administrator Norwalk,

I am quite certain that you have received extensive correspondence from my colleagues regarding our opposition to the proposed CMS changes in ASC reimbursements. Among others, their complaints include the resulting reduced access to colorectal cancer screening and unnecessary and preventable loss of countless lives. Some will even object to the unfairness of once again targeting colonoscopy for reduction in reimbursement, an action that Medicare has implemented numerous times since 1988 resulting in professional fee payments which have lagged well behind inflation.

But shouldn't the real issue here be the mounting evidence that estimates that **Medicare will be bankrupt within the next 10-15 years?** Clearly, our elderly population is growing rapidly and the coincident growth in Medicare spending is reeling out of control. Furthermore, with longer life expectancies and the higher cost of newer technologies, there is no end in sight for this worrisome trend.

Ambulatory Surgery Centers have proven the ability to provide safe, high quality care in a cost efficient environment. Patient satisfaction surveys have repeatedly indicated that patients prefer that their outpatient procedures be done in the ASC rather than in the hospital. That the hospital lobbyists have successfully convinced many of our legislators to support far more costly delivery of care without any benefit in safety, quality or patient satisfaction flies in the face of our impending Medicare crisis. The solution will only come when reimbursement

rewards fiscal responsibility without compromising safety, quality and patient satisfaction.

The future of healthcare in this country demands that we encourage the development of these highly efficient providers of quality care. Several years ago, health care costs were reduced significantly when routine care, which had previously been delivered in the costly hospital inpatient setting, was shifted toward outpatient care, resulting in greatly diminished hospital length of stay. Now we need to take the next step and encourage the movement of outpatient care out of the costly HOPD and into the far more cost efficient ASC. Hospitals will remain a place where highly technical and intensive inpatient care can be provided in the appropriate setting and at justifiable and unavoidable greater cost.

I urge you to reject this latest CMS proposal as a step in the wrong direction, and to push for legislation that provides financial incentives for the delivery of more cost effective, high quality health care.

Thank you for your consideration.

Respectfully Yours,

A handwritten signature in black ink, appearing to read "Anthony G. Auteri". The signature is fluid and cursive, with a prominent initial "A".

Anthony G. Auteri, M.D.  
Medical Director  
Eastern Pennsylvania  
Endoscopy Center

November 3, 2006

189

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

Re: **CMS – 1506 – P:** Medicare Program; CY 2007 Update to the Ambulatory Surgical Center Covered Procedures List; Ambulatory Surgical Center Payment System and CY 2008 Payment Rates; Proposed Rule, 71 *Fed. Reg.* 49,506 *et seq.* (August 23, 2006).

Dear Sir or Madam:

Please accept these comments from the Society of Ambulatory Urological Surgeons (“SAUS”) regarding **ASC Payable Procedures and ASC Ratesetting**.

SAUS was founded in 1993 to provide urologic surgeons with a forum for professional growth and exchange of insights into both the clinical and management aspects of outpatient urologic care. SAUS members have pioneered new treatment methodologies and techniques that have expanded the range of urologic surgical procedures that may be safely and effectively furnished on an outpatient basis, and which have improved patient treatment outcomes. SAUS presently represents more than 700 urologists across the United States, most of whom operate in Medicare certified ambulatory surgery and urological centers.

Since its inception, SAUS has enjoyed a productive and collaborative working relationship with CMS on matters affecting urological procedures furnished in the ASC setting. SAUS is pleased to have the opportunity to continue to work with CMS to ensure that the ASC setting is available to Medicare beneficiaries in all appropriate instances.

SAUS commends CMS for undertaking comprehensive revisions to the method by which it determines which procedures are approved for the ASC setting as well as its payment methodology for reimbursing such procedures. SAUS approves of and endorses many of CMS’s recommendations, but also has alternative recommendations with respect to several aspects.

## **I. ASC Payable Procedures**

### **A. General Methodology**

SAUS generally supports CMS’s proposal to change the methodology by which it determines which procedures will be reimbursable when furnished in the ASC setting. Over the last three decades, technological innovations have dramatically increased the range of surgical services which can be performed safely in the ASC setting. In the wake of this rapid and dynamic expansion, the traditional and current methodology has become increasingly outdated and

administratively cumbersome. CMS's proposal to revise its approach such that CMS excludes only those procedures that pose a significant patient safety risk or require an overnight stay, thereby making approval the default position, would be a vast improvement over the current framework.

Revising the approval methodology and criteria as proposed would enable beneficiaries to choose the ASC setting for a broader range of procedures and better enable the list of ASC-approved procedures to keep pace with technological advancement. Moreover, CMS's new approach would improve consistency between the Medicare ASC and hospital outpatient payment systems. SAUS encourages CMS to finalize this proposal.

**B. Listing of Surgical Procedures Proposed for Exclusion From Payment of An ASC Facility Fee Under the Revised Payment System**

Although SAUS endorses CMS's general approach to identifying procedures payable in the ASC setting, we also recommend that CMS reconsider its recommendations with respect to the following procedures:

- 50541 (Laparoscopic Ablation Renal Cyst)
- 50542 (Laparo Ablate Renal Mass)
- 50544 (Laparoscopy, Pyeloplasty)
- 50549 (Laparoscope Procedure, Renal )
- 51990 (Laparoscopic Urethral Suspension)
- 53500 (Urethrllys, Transvaginal with scope)

SAUS believes that these six procedures should be covered when furnished in the ASC.

**1. Procedures Proposed for Exclusion Because At Least 80 Percent of Medicare Cases Are Performed on an Inpatient Basis – Table 44**

For the following reasons, SAUS recommends that CMS include the following urologic laparoscopy procedures on the ASC list: 50542 (Laparo Ablate Renal Mass), 50544 (Laparoscopy, Pyeloplasty) and 50549 (Laparoscope Procedure, Renal ). First, the data upon which CMS has relied, CY 2005 Part B Extract Summary System ("BESS") data, fails to reflect recent and important shifts in the provision of these services. These procedures are relatively new. As is the case with most medical innovations, these procedures were initially performed primarily in the academic medical center setting and on an inpatient basis. Over time, however, increasing numbers of urologists outside of the teaching setting have become familiar and facile with laparoscopic technologies. Most notably, the advent of the da Vinci robot for laparoscopic prostatectomies ushered in a significant expansion of the use of laparoscopic technology by urologists. The laparoscopic skills learned in connection with the da Vinci robot are increasingly enabling urologists to furnish such procedures on an outpatient basis. Consequently, these procedures are migrating to the outpatient setting. The CY 2005 BESS data fails to account for these more recent changes in site of service.



Moreover, the BESS data represent Medicare case trends, and not site of service trends in non-Medicare populations, where it is even more common to furnish these laparoscopic procedures on an outpatient basis.

These three procedures are usually completed in under two hours and generally require less than 2 hours of supervised recovery time prior to being discharged. None of these procedures involves major vascular structures. Therefore, these procedures do not present a significant risk of blood loss for the majority of patients. Although these procedures involve renal surgery, they are very different from the laparoscopic nephrectomy procedures, which involves removal of the kidney and, hence, major vascular structures. These three procedures thus present significantly less risk than the laparoscopic nephrectomy.

Finally, technological advancement in anesthesia and laparoscopes makes it safe and appropriate to perform these procedures in the ASC.

## **2. Procedure Codes Proposed for Exclusion Because They Require an Overnight Stay**

An overnight stay is not prevailing medical practice for CPT codes 50541 (Laparoscopic Ablation Renal Cyst), 51990 (Laparoscopic Urethral Suspension) and 53500 (Urethryls, Transvaginal with scope). These procedures are frequently performed on an outpatient basis. In fact, according to American Medical Association 2004 RUC data, CPT code 50541 is furnished in an outpatient setting 21.32 percent of the time; CPT code 51990 is furnished in an outpatient setting 29.05 percent of the time; and CPT code 53500 is furnished in an outpatient setting 48.62 percent of the time. Moreover, these procedures are typically completed in under 2 hours and generally require less than 2 hours of supervised recovery time prior to discharge. In addition, none of these procedures involve vascular structures and do not require pneumoperitoneum. Overall, these procedures involve little risk to the patient. Patients receiving such procedures in the morning can easily be discharged well before midnight.

## **II. ASC Payment for “Office-based” Procedures**

SAUS appreciates CMS’s concerns regarding the potential migration of “office-based” procedures to the ASC setting as a consequence of providing an ASC facility fee. Nonetheless, SAUS disagrees with CMS’s proposal to address this concern by capping payment for office-based procedures at the amount it pays a physician’s office for the same procedure. Our concerns are detailed more extensively below. However, if CMS proceeds with the proposed cap, SAUS strongly supports the proposed exemption for procedures that are on the ASC List prior to January 1, 2008.

### **A. The Proposed Cap Would Unreasonably Reimburse ASCs**

Each procedure currently on the ASC list has been specifically approved by CMS for the ASC setting. This approval represents an affirmative determination by CMS that beneficiaries should have the option of having these procedures performed in the ASC setting. Therefore, CMS should commit to providing reasonable reimbursement for these procedures. Capping reimbursement for office-based procedures at the level CMS would pay a physician's office does not constitute reasonable reimbursement. To the contrary, this level of reimbursement fails to account for the increased costs and complexities associated with performing procedures in the ASC setting. ASCs would be effectively prohibited from performing these procedures at this level of reimbursement because they would be unable to recoup their costs.

### **B. A Subset of Medicare Patients Require Facility-level Resources**

Although most patients can safely receive "office-based" procedures in the office setting, some patients require the added resources of a facility. For example, patients who have diabetes, immune deficiencies, or otherwise require antibiotic prophylaxis should only receive invasive surgical procedures in a sterile environment. Similarly, patients with urologic abnormalities – such as prostate cancer – may experience significantly more pain during surgical procedures, and therefore require higher levels of sedation. For these patients, a facility setting is necessary because it offers advanced anesthesiology and monitoring capabilities.

If the ASC is no longer an option for such patients, these procedures will be performed in either the office setting, which may pose patient safety risks, or the hospital setting, which results in higher costs to both beneficiaries and the Medicare program.

### **C. CMS Should Exempt Procedures On The ASC List Before January 1, 2008 From the Capped Payment**

CMS is right to exempt procedures that are currently on the ASC List from the physician office cap. Procedures that otherwise would qualify as "office-based" that have been on the ASC List will not migrate further to the ASC setting. Any migration that would result has already occurred, and no further practice pattern shift should be expected. In fact, despite an increase in the number of ASCs in recent years, CPT codes 52000 and 55700 are furnished no more in the ASC setting today than they were in 1997. These procedures have consistently been furnished in hospital or ASC settings in 25 to 28 percent of cases over the years 1997 to 2003. These patients will almost certainly be treated in a hospital environment if the ASC is no longer a financially viable option. Imposing a cap on these procedures would be tantamount to a penalty and an affirmative policy intended to discourage these procedures from the ASC setting.

## **III. ASC Ratesetting: ASC Conversion Factor and ASC Phase-in**

SAUS commends CMS for taking the initiative to change the reimbursement methodology for services provided in ASCs. SAUS believes that basing reimbursement on the OPPTS will create necessary transparency and continuity across the outpatient care continuum and result in more appropriate reimbursement to ASCs.

However, SAUS disagrees with the proposed **ASC Conversion Factor** and the proposed **ASC Phase-in** as they apply to procedures that involve high-cost prosthetic implants and leased technologies.

**A. The ASC Conversion Factor is Too Low to Ensure Appropriate Reimbursement**

The proposed conversion factor of 62 percent for CY 2008 is too low and overstates the savings achieved in the ASC setting as opposed to the hospital outpatient department. SAUS is not equipped to provide CMS with a technical critique of its budget neutrality assumptions. Other, much larger ASC trade associations will undoubtedly provide that analysis. However, as a matter of fairness, CMS cannot reasonably believe that the cost to an ASC of furnishing a given procedure is only 62 percent of the cost to a hospital of furnishing that same procedure. Although we recognize that CMS was constrained by statutory mandates, we believe that CMS has and should exercise some discretion within these mandates to reach a more reasonable and credible result.

**B. The Proposed Conversion Factor and Phase-in Are Inappropriate for Procedures that Involve High-cost Prosthetic Implants or Leased Technologies**

The conversion factor will effectively prohibit ASCs from performing procedures that involve high-cost prosthetic implants or leased technologies. In many of these instances, the facility fee is comprised almost entirely of the cost of the implant or leased technology. Because hospitals and ASCs both bear the cost of the implant or leased technology equally, application of the conversion factor to these procedures would result in serious underpayment to the ASC. This underpayment would result in such procedures no longer being performed in the ASC because the ASC would be unable to recoup the cost of the implant or leased technology.

For example, the proposed 2007 hospital reimbursement for CPT code 53445 (Insert uro/ves nck sphincter) is approximately \$8,354. The cost for the implant provided in this procedure alone is \$7195. If the payment to an ASC for this procedure is \$5,386 without the transition, ASCs will quite simply be unable to furnish these procedures. This problem is compounded in the transition year where CMS proposes a payment of only \$2,859.

The same problem exists with respect to procedures that involve high-cost leased technologies, such as lithotripsy, CPT code 50590 (Fragmenting of kidney stone). In this instance, the proposed 2007 hospital reimbursement for CPT code 50590 is approximately \$2,715. The payment to an ASC for this procedure would be \$1,750 without the transition and \$350 in the transition year.

In instances where high-cost implants or leased technologies account for a significant percentage of the overall cost of furnishing the procedure, CMS should make some special adjustment to the conversion factor and dispensation during the transition year. Even if one accepts the premise that ASCs operate more efficiently and at a lower cost than hospitals, ASCs are not able to obtain these implants or technologies at a lower cost than their hospital counterparts. In fact, the

opposite may be the case, since ASCs oftentimes do not enjoy the same market power and cannot avail themselves of mechanisms like group purchasing organizations to obtain discounts on implants and technologies.

SAUS recommends that CMS apply the discount only to the non-device portion of the APC payment in the revised ASC payment system. Instead of applying the proposed 62 percent conversion factor to all ASC services, a specific adjustment should be made that allows ASCs to receive payment for 100 percent of the device-related percentage of the OPPS APC payment. CMS should then apply the 62 percent adjustment to the remaining non-device related percentage of the ASC payment. Moreover, CMS should exempt procedures with high-cost implants or leased technologies from the transition, and begin paying ASCs the new reimbursement immediately upon implementation.

This proposal is consistent with the policy underlying the multiple procedure discount exemption for procedures involving high-cost implants. Under the OPPS, surgical procedures with costly implants are not subject to the discounting policy when performed in association with other surgical procedures because the cost of the implantable device does not change, so resource savings due to efficiencies are minimal. The same is true with respect to the hospital and ASC. Any efficiencies that are ascribed to the ASC vis-à-vis the hospital do not extend to procedures involving costly implants or leased technologies.

The following urologic CPT codes involve high-cost implants and should be specially treated as described above:

- 53440 (Male sling procedure)
- 53444 (Insert tandem cuff)
- 53445 (Insert uro/ves nck sphincter)
- 53447 (Remove/replace ur sphincter)
- 53449 (Repair uro sphincter)
- 54400 (Insert Semi-rigid prosthesis)
- 54401 (Insert self-contd prosthesis)
- 54405 (Insert multi-comp penis pros)
- 54408 (Repair multi-comp penis pros)
- 54410 (Repair/remove penis pros)
- 54416 (Remv/repl penis contain pros)
- 64561 (Implant neuroelectrodes)
- 64581 (Implant neuroelectrodes)

All of the procedures above are also designated as being exempt from the multiple procedure discounting policy, because they involve costly implants.

The following urologic CPT codes involve high-cost leased technologies and likewise should be specially treated as described above:

- 50590 (Fragmenting of kidney stone)
- 52647 (Laser surgery of prostate)

- 52648 (Laser surgery of prostate)
- 55873 (Cryoablate prostate)

\* \* \*

Thank you for your thoughtful consideration of these matters. Please call me at (352) 237-8100 or Eric Zimmerman, SAUS's Washington Counsel, at 202.756.8148 if we can be of assistance in any way.

Sincerely,

A handwritten signature in black ink that reads "Ira Klimberg" with a stylized flourish at the end that looks like "(JK)".

Ira Klimberg, M.D.  
President

cc: Eric Zimmerman



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.

191

**Cumberland Foot and Ankle Centers****Jonathan Moore D.P.M.****Pamela Jensen-Stanley D.P.M****Christopher Miller D.P.M.**

311 N. Langdon Street

Somerset, KY 42503

606-679-2773

November 6, 2006

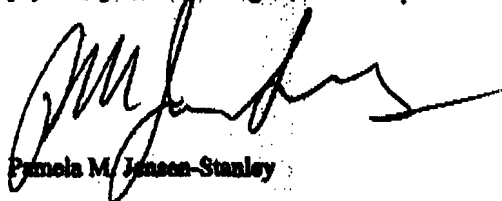
Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

Dear Sirs,

We are writing you regarding the following points:

- \* Medicare beneficiaries' need access to ASC's. The CMS should broadly interpret the budget neutrality provision enacted by Congress. 62 % is not enough to support these services.
- \* The ACS list is too limited and should include all procedures that can be performed by an HOPD
- \* The ACS should be updated by the hospital market basket as it reflects inflation in providing surgical services.
- \* Aligning the payment system for ASCs and hospital outpatient departments will improve the cost and quality of care used to evaluate outpatient surgical services for Medicare beneficiaries.

We believe that the interests of the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.



Pamela M. Jensen-Stanley

# HEALTHSOUTH

Surgery Center of Dallas

192

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

As members of the healthcare community we have been involved in serving the Medicare population for many years. We feel that if you continue to negatively impact the Ambulatory Surgery Center Community we will not survive and that the outpatient hospital service will be the only alternative left. This would be a shame. We deliver safe, quality, affordable care to those who struggle to make ends meet. By forcing patients into the hospital based system you will greatly increase the cost to our Medicare patients. This will negatively impact the patient's ability to access and receive the care they need. Unless this is your goal, please consider the following information:

- The ASC reimbursement system should be modeled on the methodology applicable to surgical services furnished in hospital outpatient departments ("HOPD's"), with ASC's paid on the basis of a reasonable percentage of the rates paid to HOPD for the same services. This will create the proper incentives for beneficiaries and physicians to use a less costly setting when medically appropriate. This should include the same pass-through payments for medical devices or other new technologies in both settings.
- ASC payment rates should be updated annually in coordination with HOPD rates.
- Changes to the ASC reimbursement system should be phased in over a multi-year period. Special rules should be established to prevent disruptive or excessive one-time price changes for some procedures and to ensure a smooth transition to a new payment system.
- The Medicare beneficiary's co-payment should remain at 20% of the service (as provided under current law), which will ensure that patients will pay less for surgical services provided in ASCs.
- Any new system should allow ASCs to perform and receive payment for any surgical service covered in an HOPD unless (1) the service requires an overnight stay; or (2) the Secretary of the Department of Health and Human Services has determined that performance in an ASC would pose a significant risk to safety.

We ask your support for these key principles as ASC reimbursement reform moves forward in order to ensure that patients are given access to the best choices available.

Sincerely,



Christine Locke, Administrator  
HealthSouth Surgery Center of Dallas





# Day Surgery

OF  
GRAND JUNCTION

193

October 30, 2006

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

Dear Reviewer:

We are writing regarding the proposed ASC reimbursement rates planned for 2008.

Medicare beneficiary's access to Ambulatory Surgery Centers must be preserved. CMS should more broadly interpret the budget neutrality provision enacted by Congress. 62% is not adequate.

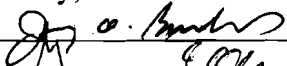
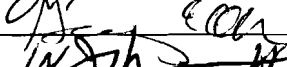


As an ophthalmic ASC, we take pride in providing expert eye care for our patients at an affordable price. We strongly believe our economical and efficient services are a valuable asset to our community and are hopeful we can continue to provide this service. However, due to the rising costs of labor and supplies our expenses continue to climb. Decreasing our ASC's reimbursement as proposed will have detrimental affects on our ability to continue providing sight-saving procedures. All ASCs standings should be updated based on the hospital market basket. This method more appropriately reflects inflation in providing surgical services than does the Consumer Price Index. Equally, the same relative weights should be used in ASCs and HOPDs.

We also feel this reformed list proposed by CMS is too limited and should be expanded to include any and all procedures that can be performed in hospital outpatient department (HOPD). CMS should exclude only those procedures that are on the inpatient only list

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.

Thank you for your consideration in this important matter.

Sincerely,

 Jerry O. Bush M.D.  
 Gregory E. Kellam M.D.  
 Walter J. Hoffman M.D.  
 Kristin K. Brim RN, Administrator

# Alaska Surgery Center

A HEALTHSOUTH SURGERY CENTER

194

October 30, 2006

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
P.O. Box 8011  
Baltimore, Maryland 21244-1850

Dear CMS,

I am writing this letter on behalf of the Alaska Surgery Center in Anchorage, Alaska in hopes of helping drive changes in the current policies. We are an outpatient surgery center serving a population of approximately 400,000 people here on the last frontier. Our nursing and technical staff is well-trained, with the majority of them having fifteen to twenty or more years in the nursing and perioperative fields. Most of our staff got their training in the hospital setting and brought that expertise to the specialized area of outpatient surgery. The anesthesia provided in this center is clearly equal and in some regards superior to that afforded at the local hospitals. Our physicians are among the finest found anywhere in the country and are recognized experts in their respective fields. They operate at the local hospitals as well as our facility and for the most part, perform the same procedures at all locations.

Here at the Alaska Surgery Center, we provide top-quality, outpatient surgical care to approximately 5,500 patients annually. Our surgical outcomes are undoubtedly equal to those performed in the hospital environment. Because we are specifically geared for outpatient surgery, we are able to provide a much more efficient and therefore more cost-effective service than our hospital counterparts. We do, however have many of the same constraints with regard to cost of supplies, shipping, and the recruiting and retaining of qualified staff.

The current payment policies and restrictions on allowable procedures limit our ability to serve more of the Anchorage and Alaskan populace. We receive significantly less reimbursement while using the same physicians, anesthesia, staff, and supplies and performing identical surgical procedures with identical outcomes as those performed in the hospitals. This gap has only widened in the last six years and will continue to do so if reform is not instituted.

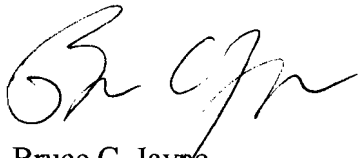
We would like to ask that change be effected that will discontinue some of the limits on outpatient surgical procedures performed in ambulatory settings. We are a sound, viable, competitive alternative to the hospitals and can definitely save the Medicare system and its beneficiaries both money and time. We are asking that the limits on types of allowable procedures be lifted, that those decisions be allowed to fall to the physicians and patients. We also ask that our reimbursement be in line with that of our hospital counterparts, after all, we are providing the same services and share many of the same costs.

# Alaska Surgery Center

A HEALTHSOUTH SURGERY CENTER

On behalf of all of the highly trained professionals at the Alaska Surgery Center, I would like to thank you for your time and attention to this matter. I look forward to positive changes on the horizon with regard to Medicare Modernization and a promising future. If I can be of any assistance, please feel free to contact me.

Sincerely,



Bruce C. Jayne  
Administrator,  
Alaska Surgery Center



Brion J. Beerle, M.D.  
Medical Director  
Alaska Surgery Center

Centers for Medicare and Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

10/27/06

CMS:

As the Administrator of the *Surgery Center of Santa Monica*, it behooves me to point out the problems in the proposed CMS ruling regarding ASC payment and procedure list. My job is to offer physicians in my community the option to care for their patients here at the surgery center, the convenient and less expensive option than the local hospital outpatient department.

- **Don't cut the reimbursement rate of an ASC and reward the inefficiency of hospital based treatment.**

If the estimated payment to ASCs is slated to be only 62% of HOPDs for providing the identical outpatient surgical services, it's the patient that loses out. ASCs have been providing Medicare and its beneficiaries a way to save money by offering a competitive alternative to the hospital outpatient department for years now, don't let this CMS rule jeopardize this opportunity.

- **Expand the list and 'maximize choices' for the Medicare beneficiary by increasing the number of approved ASC procedures.**

In '05, Secretary Leavitt wrote to Congress that HHS would free up the potential list of procedures that could be performed in an ASC. The list did grow but CMS failed to include a number of more complex procedures that have been currently done in ASCs for years now. Again, when an ASC's ability to perform certain procedures is jettisoned by not showing up on a government list, it's the patient that loses out.

I know I represent one in-network surgical center in Southern California, but the *Surgery Center of Santa Monica* performs over 300 cases a month in various specialties and provides our physicians and their patients with high quality, cost sensitive care. Don't let these two issues of reduced reimbursement and limited procedural approval stand in the way of this ASC's ability to provide for its Medicare beneficiaries.

Sincerely,



Bill Aronis  
Administrator

October 31, 2006

Centers for Medicare and Medicaid Services  
CMS-1506-P  
Department of Health and Human Services  
POB 8011  
Baltimore, MD 21244-1850

Dear Administrator Norwalk:

Our group will perform over 2000 orthopaedic related procedures on Medicare patients in 2006. We will have to seriously consider our ability to provide services to the Medicare population in the future. The 62% of hospital outpatient surgery rates that has been proposed is simply inadequate compensation for the orthopaedic procedures that we perform. We compete for the same personnel that our local hospitals wish to hire and retain and our supply costs are equivalent to or higher than the local hospitals. It is therefore inconceivable that we should be reimbursed at 62% of what a hospital is paid for the exact same procedure.

Future increases in payment rates should be based on the same criteria that CMS utilizes to increase reimbursement to hospitals. Again we are competing with the hospitals for the same resources and experience the same rates of inflation that hospitals do. Therefore we need the same rate of increase in rates.

Thank you for considering these comments.

Sincerely,



Jim Webster  
Administrative Director  
The Orthopaedic Surgery Center

**Bard Urological Division**

C.R. Bard, Inc.  
13183 Harland Drive  
Covington, GA 30014  
(678) 342-4801

197

BARDED

**Mark O. Downey**  
President

November 3, 2006

Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1506-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

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

Dear Ms. Norwalk:

On behalf of C. R. Bard, Inc., I am pleased to offer the following comments on the Centers for Medicare and Medicaid Service's (CMS) Proposed Ambulatory Surgical Center Payment System and CY2008 Payment Rates, (CMS-1506-P, *Federal Register*, Vol. 71, No. 163, Tuesday, August 23, 2006, p. 49505). C. R. Bard, Inc appreciates the considerable effort you and your staff have put into the development of this proposed rule.

For almost 100 years, C. R. Bard, Inc. has committed its resources to creating innovative products and services that meet the needs of healthcare providers and patients. Today, Bard is a worldwide leader in products that focus on disease state management in three key areas: Vascular, Oncology, and Urology. Bard is committed to advancing the technology of diagnosis and intervention to help reduce healthcare costs and improve patient outcomes. Founded in 1907, C. R. Bard has facilities in 8 U. S. locations and in 20 other countries around the world, and employs more than 8,100 people.

Bard's Urological Division is the worldwide market leader in Urological Diagnostic and Interventional Products with a focus on urological drainage, continence, and prostate disease management. The Division offers a wide range of brachytherapy products and services to service the brachytherapy market. It is the goal of the division to ensure that all interested clinicians may easily and cost-effectively become knowledgeable participants in this emerging therapy and patients have access to these emerging therapies.

Bard Urological Division appreciates the time and effort CMS has devoted to the development of the revised Ambulatory Surgical Center (ASC) payment system and the development of the

2008 ASC payment rates. Our comments below address the concerns we have with certain issues within the proposed rule.

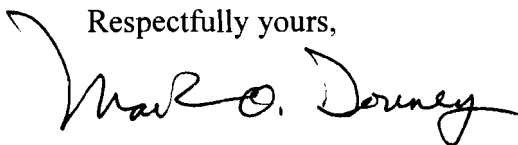
Bard Urological is concerned with the CMS proposal to package the direct and indirect estimated costs incurred by a facility to perform a surgical procedure into the ASC facility fee payment. This proposed CMS methodology does not take into account the unique costs incurred by the ASCs for device-dependent procedures. The cost of devices is consistent regardless of the setting of care. Furthermore, we are concerned by the proposal to cease making separate payments to ASCs for the costs of surgically implantable devices. This proposed packaging of costs would provide significantly reduced payments for these procedures thereby reducing the ability for ASCs to provide these procedures, reducing or preventing beneficiary access.

Currently, brachytherapy sources are paid separately in the outpatient hospital and ASC settings. We encourage CMS to continue this policy under the new ASC payment system.

We would like to bring to CMS's attention a technical error in the proposed rule. In the proposed rule CPT 57267 - Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure), a new code in 2005, is included in "Table 45. -- CPT Surgical Procedure Codes Proposed for Exclusion from ASC Facility Fee Payment Because They Require an Overnight Stay". CPT 57267 is equivalent in intent and function to CPT 49568 – Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair). In Outpatient Hospital, both codes have the same RV Value and crosswalk to the same APC. In the ASC, CPT 49568 crosswalks to Payment Group 7. CPT 49568 is coded in conjunction with CPT 49560, 49561, 49565, or 49566, all approved procedures in an ASC. CPT 57267 is coded in conjunction with CPT 57240, 57250, 57260, 57265, or 45560, all approved procedures in as ASC. In light of the just published 2007 Final Rule, which includes CPT 57267 as an approved procedure in an ASC, we ask that CPT 57267 be added to the 2008 approved ASC list with a Group 7 payment.

Thank you for your consideration of these comments and recommendations. We at C. R. Bard's Urological Division stand ready to assist you should you have any questions with respect to these comments or prostate brachytherapy therapy. We encourage you to contact George Clark, who manages our reimbursement efforts, if you have specific questions about these comments. He can be reached by phone (678-342-4850) or e-mail ([george.clark@crbard.com](mailto:george.clark@crbard.com)).

Respectfully yours,



Mark O. Downey  
President  
Bard Urological Division



198

10/30/06

Mark B. McClellan, M.D., Ph.D., Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-4125-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

Re: CMS -4125-P

Dear Dr. McClellan:

I am the Administrator of Oasis HealthSouth Surgery Center in San Diego, California. Each year, our surgery center provides approximately 200 procedures to 175 Medicare beneficiaries. Medicare patients represent 8% of our business and ensuring appropriate payment for their services is vital to our ability to serve our community.

Ambulatory surgical centers (ASC's) provide patients with a high-quality, convenient and less expensive option for their outpatient surgery. When Medicare beneficiaries choose ASCs for their outpatient surgery, they and Medicare save money.

The six year payment freeze to ASCs and the cuts in the Deficit Reduction Act have resulted in much lower payments to ASCs relative to payments made when services are provided in the HOPD. HOPD has received significant payment updates. The proposed rule estimates that ASCs should be paid only 62% of HOPD for providing the identical outpatient surgical services.

This low payment rate will result in significant cuts to a number of important, commonly performed services in ASCs including GI and ophthalmology. At the same time, payments for other specialties such as orthopedics will rise but it is not clear whether they will increase enough to become viable and be provided ubiquitously at ASCs.

The proposed rule would tie ASCs payments to the Hospital Out Patient Prospective Payment System (HOPPS) in some but not all respects. CMS can help Medicare



beneficiaries save money by making ASCs a viable, competitive alternative to outpatient hospitals by fixing the following problems in the proposed rule.

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 fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care.

The ASC community is working with Medicare payment experts to present quantitative analysis on the ASC percentage of HOPD that should be provided if CMS adopts a realistic interpretation of budget neutrality that examines the impact on the new ASC payment system on all Medicare spending on outpatient surgery. We expect that number to be substantially higher than the 62% CMS announced in its "alternative methodology".

ASC's confront the identical inflationary pressures as hospitals – hiring and retaining qualified OR nurses, purchasing medical supplies and implants. The proposed update should be based on the hospital market basket update. The disparity in payments will create deeper divisions between prices paid in the HOPD and the ASC without any evidence that different payment rates are warranted.

The ASC payment systems administered by CMS are bound by a list of permitted procedures determined by CMS. While the proposed rule would add 750 procedures to the ASC list, most are low complexity. These procedures are capped at the physician fee schedule rate and not paid using a percentage of HOPD rates. CMS has failed to include, on this procedure list, a number of higher complexity services that have been safely and effectively performed in ASCs through the country for years. CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeons.

The proposed rule continues to treat HOPD and ASC's differently in some key aspects. These differences should be eliminated and payments made to ASCs and HOPD should be made on the same reimbursement structure. Many procedures that could be safely performed in the ASC will not be available because payments will remain below cost. (i.e., there are a number of orthopedic procedures that are currently grouped in an inappropriate payment group on the ASC list. The groupings do not reflect the current standard of care in the allocated reimbursement. Implant costs attached to the orthopedic procedures are not reimbursed separately and the costs to perform these procedures are higher than current payments). Ensuring that the reimbursements remain above costs is vital to the safety and quality of care our Medicare population is receiving.

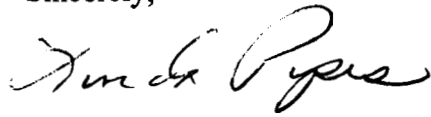
Our nation has made considerable progress by adding a prescription drug plan to the Medicare benefits. Anything we can do to reduce the out of pocket expenses for our seniors is important to their quality of life.

Payment levels for ASCs should be set at similar levels to allow full reimbursement for DME costs. The more we can do to decrease the discrepancies between HOPD and ASC's will keep us moving forward in the quality of care our seniors are receiving and

providing safe, cost effective treatment for our Medicare population as well as the Medicare program.

Thank you for your time and consideration of my concerns regarding CMS-4125-P.

Sincerely,

A handwritten signature in cursive script that reads "Linda Pipes". The signature is written in black ink and is positioned above the typed name.

Linda Pipes  
Administrator

October 26, 2006

Mark B. McClellan, MD, PhD, Administrator  
Center for Medicare & Medicaid Services  
Department of Health and Human Resources  
Attention: CMS-4125-P  
PO Box 8011  
Baltimore, MD 21244-1850

Dear Sir:

The Medicare Modernization Act requires that ASC's be transitioned from their current Medicare payment system to a new payment system by 2008. This Act provides an opportunity to provide more transparency ("apples to apples" comparisons) across sites of service and permits ASC's to be a vital and viable competitive alternative to the more expensive outpatient hospital departments (HOPD).

MedPac and the ASC community support moving to the hospital outpatient prospective payment system (HOPPS) as long as it is fair and equitable to both facilities. The six year payment freeze to ASC's & the cuts in the Deficit Reduction Act have resulted in lower payments to ASC's in comparison to payments for procedures performed in HOPD (which received significant payment updates) over the same period of time. Inflationary cost and operational cost affects ASC's in the same way as hospitals and shouldn't result in a payment freeze to an industry that has demonstrated its ability to save Medicare beneficiaries & CMS money.

It is clear that the new payment system and expansion of procedures being performed in ASC's will result in migration of services from one site of service to another. Your agency has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment rates on all sites of care (physician office, ASC, & HOPD). My industry has been working proactively with respected actuarial and Medicare payment experts to develop a quantitative analysis model which examines the impact of the proposed Medicare spending for outpatient surgery on ASC's. Our investigation indicates that the number will be substantially higher than the 62% that CMS announced in its "alternative methodology". By setting rates this low, CMS is encouraging ASC's to cancel these procedures because of marginal reimbursements and forcing doctors to move cases to the more expensive hospital setting (increasing the amount of money paid by Medicare beneficiaries and the federal government).

Shouldn't CMS use the same measurement mechanism (CPI or Market Basket Update) for reimbursing both facilities rather than creating a greater disparity in payments by using different measurements? The Moran Company recently submitted a report to CMS that high-lighted facility payments in 2005. Medicare, spent \$1.1 billion less for surgical services being performed in ASC's versus what you would have paid if these same services had been provided in HOPD's. Medicare certified ASC's have proven over the past two decades that they are capable of safely performing the same scope of services provided in HOPD's. Speaking on behalf of my fellow administrators and tax payers, I am encouraging to you exercise good fiduciary judgment in developing a payment system that is fair and equitable for surgical facilities interested in providing the highest quality of care in the most cost effective manner to healthcare consumers.

Thanks for affording me the opportunity of expressing my views during this comment period.

Best personal regards,



Bob Gilbert,  
Administrator



RESURGENS<sup>PC</sup>  
ORTHOPAEDICS

200-0  
(173)

November 01, 2006

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

**Re: 2007 OPPS Proposed Rule (CMS-1506-P) – Comments on Proposed Revised Ambulatory Surgical Center Payment System for Implementation January 1, 2008 (Section XVIII)**

Dear Administrator Norwalk:

I am writing to you concerning the above Rulemaking published on June 12, 2006, regarding updates to rate-setting methodology, payment rates, payment policies, and the list of covered surgical procedures for ambulatory surgical centers. I am a physician staff member at the Lawrenceville Surgery Center, a single specialty center for orthopaedic care located in Lawrenceville, Georgia.

The goal for all of us--providers, physicians, and payors--is to create a health care system that delivers excellent clinical outcomes in a cost efficient environment.

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a **unique** opportunity to better align payments to providers of outpatient surgical services. Given the antiquated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. The following comments focus on three principles:

- maximizing **parity between the ASC and HOPD payment systems** to prevent differences between the payment systems
- 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.

**1. ASC Payable Procedures (Section XVIII.B.1)**

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.

**2. ASC Unlisted Procedures (Section XVIII.B.2)**

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.

**3. ASC Office-Based Procedures (Section XVIII.B.3)**

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.

**4. ASC Ratesetting (Section XVIII.C.2); ASC Packaging (Section XVIII.C.3); ASC Payment for Office-Based Procedures (Section XVIII.C.5); ASC Multiple Procedure Discounting (Section XVIII.C.6); ASC Wage Index (Section XVIII.C.7); ASC Inflation (Section XVIII.C.8)**

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.

**5. ASC Coinsurance (Section XVIII.C.9)**

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 OPSS.

**6. ASC Phase-In (Section XVIII.C.10)**

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.

**7. ASC Conversion Factor (Section XVIII.C.11)**

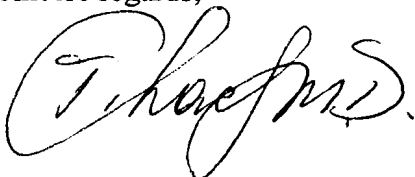
62 % conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases 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.

**8. ASC Updates (Section XVIII.C.12)**

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 OPSS 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.

If you have questions or would like to visit me regarding my comments, I can be reached at *(telephone number)* and again my sincere appreciation for the work and commitment of CMS to the patients each of us serves.

Sincere regards,



Tamara Chachashvili, M.D.