CMS-1392-P-684 **Medicare**

Submitter : Clark Glickman **09/11/2007**

Organization : Clark Glickman
Social Worker

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

Each day we treat many patients who are severely depressed and need intensive Psychiatric treatment. For many such patients PHP and other outpatient Psychiatric treatment is the best choice. It allows the patient to put into practice the concepts and techniques learned in their home environment, and is the most cost effective and least restrictive treatment for these patients. Without this service, many would be admitted much more frequently to Inpatient hospital units where the primary goal is to stabilize them with medication and discharge them ASAP. This is of little benefit to the patient or the taxpayer, and is not an effective treatment for long-term stabilization and safety. Please allow these patients to continue to receive the care they need so dearly and do not reduce the already low payment considering the intensity of the services. I realize several bad apples (providers) have abused the program, and they must be held accountable. However, most of us assess and provide the appropriate level of treatment for each patient we encounter, and the ones who lose if the service is no longer available is the patient and the Medicare Trust Fund, as Inpatient treatment will become the only option. This is a wasteful, ineffective means of treating patients with severe Psychiatric illnesses. Please consider the needs of this segment of our community who need these services and do not decrease the rate. sincerely, Clark

CMS-1392-P-685 **Medicare**

Submitter : Dr. Luis Escobar **09/11/2007**

Organization : Pain Care Specialists of Florida
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1392-P-685-Attach-1.DOC

#685

September 11, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1392–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1392-P

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the Proposed Rule CMS-1392-P, "Proposed Changes to the Hospital Outpatient P rospective Payment System (HOPPS) and CY 2008 Payment Rates" (the Proposed Rule) published in the *Federal Register* on August 2, 2007. My comments cover two main issues related to the HOPPS and ambulatory surgery center (ASC) payment methodologies.

I. ASC Procedures

There are several specific procedure issues we ask CMS to review and address. I believe that two procedures that have not been included on the ASC payment list, but that are paid under the HOPPS and should also be included on the ASC list. These procedures are described by CPT codes 22526 (percutaneous intradiscal electrothermal annuloplasty, single level) and 22527 (percutaneous intradiscal electrothermal annuloplasty, one or more additional levels). There is no reason why ASCs should not be entitled to payment for these two procedures. The procedures are safely done in ASCs, and they are not procedures routinely performed in a physician's office. I ask CMS to include both procedures on the ASC list in the final rule.

ASIPP also is concerned that procedures 72285 (discography - cervical or thoracic - radiological supervision and interpretation) and 72295 (discography – lumbar - radiological supervision and interpretation) have been packaged in all circumstances under the ASC proposed rule. These services are payable separately in the HOPD in certain circumstances and I believe the same should be true for ASCs.

Lastly, I ask CMS recalculate the payment rate of CPT code 64517. The proposed payment rate for this procedure is $178 for CY 2008. While I do recognize that the payment for the procedure following the transition period will be $295, a payment of $178 seems too low.

II. IMPLANTATION OF SPINAL NEUROSTIMULATORS

I ask that CMS create a new APC for implanting rechargeable neurostimulators upon expiration of the new technology transitional pass-through payment at the end of 2007.

I am concerned that the CMS proposal to pay rechargeable and non-rechargeable neurostimulator procedures under the same APC (0222) ($12,314 in hospital outpatient departments and $10,925 in ASCs) will impair Medicare Beneficiaries access to neurostimulation therapy utilizing rechargeable devices. The proposed payment structure could lead to such financial pressures on

the facilities purchasing these devices and ultimately cause the restrictive use of this technology despite the fact that rechargeable devices represent a major improvement in neurostimulation therapy for patients with chronic pain. If access to the rechargeable technology is inhibited than Medicare beneficiaries in need of this type of treatment for chronic pain will be relegated to non-rechargeable technology and subject to the risks and co-insurance costs associated with repeat surgical procedures for battery replacement. This outcome seems inconsistent with CMS's own determination that this technology offers beneficiaries substantial clinical improvement over non-rechargeable implantable which was evidenced by the decision to grant rechargeable implantable neurostimulators new technology pass-through payments for 2006 and 2007.

Implantable neurostimulators ensure that chronic pain patients have consistent pain control without interruption. The clinical benefit of the first generation non-rechargeable neurostimulator technologies is limited by the need for repeat surgical procedures for battery replacement any where from every two to four years depending on the usage of the device. Unfortunately, what we know from experience is that many physicians using non-rechargeable battery devices will utilize program settings that require less power in order to conserve the life of their non-rechargeable battery. This practice compromises the patient's opportunity to obtain optimal pain relief on a day-to-day basis; but patients choose this option as opposed to undergoing another surgical procedure. Rechargeable neurostimulators are capable of delivering continuous stimulation, even at high levels, to optimize patient relief without concern of rapid battery depletion.

Approximately 25 to 30 percent of all the neurostimulator implant procedures performed each year are required to replace a depleted, non-rechargeable battery. Thus, in the long term, the use of rechargeable devices likely would result in cost savings to the Medicare program and beneficiaries due to the decreased need for battery replacement procedures. The need for fewer surgeries also would reduce the chances that patients will experience operative complications such post-operative infection or other possible co-morbidities.

I ask CMS to create an APC for procedures using rechargeable implantable neurostimulators that is separate and distinct from the proposed APC grouping (0222) to create greater resource consistency. While we appreciate that CMS wants to bundle similar procedures that may utilize a variety of devices with different costs, it is inappropriate to bundle procedures when the absolute difference in cost is so significant. CMS's own analysis of the claims data associated with APC 0222 (shown in Table 35 of the preamble) reveals significantly higher costs for procedures associated with rechargeable neurostimulators ($18,089 median cost) than non-rechargeable neurostimulators ($11,608 median cost).

While I recognize the difference in median costs does not create a two times rule violation, the difference in median cost is not insignificant. CMS has assigned pass-through devices to a new APC or to a different, existing APC in absence of a "two-times" rule violation and for median costs differences significantly less than $1,000. I urge CMS to take a similar approach here. The creation of two separate APCs would result in more appropriate payment for both types of procedures—rechargeable and non-rechargeable neurostimulator procedures—based on their relative costs. To implement our recommendation, we further recommend that CMS create a G-Code to distinguish between implanting a rechargeable and a non-rechargeable neurostimulator.

Moreover, ensuring the payment rate is appropriate under the HOPPS system will result more appropriate payment in the ASC setting. Today, ASCs receive reimbursement for rechargeable generators through the DMEPOS fee schedule (L8689- rechargeable generator). With the current proposal ASC reimbursement will be based on 100% of the device component and approximately 65% of the service component of the APC payment. If the device component, as determined from the OPPS claims data, is based on a mix of rechargeable and non-rechargeable device costs, payments to ASCs will vastly underpay for the actual equipment, which costs the same in all

settings. Now that the two payments systems are inextricably linked it is even more incumbent upon CMS to ensure that payments are adequate under the HOPPS or Medicare beneficiaries may be left without an option to have this procedure performed at a HOPD or an ASC.

In summary my recommendations to CMS are:

- Create a new APC for procedures using rechargeable neurostimulators to recognize the full device and facility costs associated with these procedures.
- Establish new HCPCS II "G-codes" to differentiate between rechargeable and non-rechargeable neurostimulators.
- Alternatively, CMS could continue using the device C-code, C-1820, to assign rechargeable neurostimlutor procedures to a new APC.
- Maintain non-rechargeable neurostimulator procedures in APC 0222.

***

Thank you for your consideration of my comments.

Sincerely,

Luis A. Escobar, MD
3510 NE 23 AVE
Lighthouse Point, FL 33064

CMS-1392-P-686 **Medicare**

Submitter : Ms. Randi Hackbarth **09/11/2007**

Organization : John Muir Behavioral Health Center
Psychiatric Hospital

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

Re: Response to Proposed Changes to the CY2008 Hospital Outpatient PPS-CMS-1392-P Partial Hospitalization (APC 0033)

On behalf of John Muir Behavioral Health Center□s Partial Hospital Program (JMBHC), we appreciate the opportunity to submit comments. JMBHC is deeply concerned about the direct impact a fourth consecutive rate reduction will have on partial hospitalization and hospital outpatient services. We believe this rate cut will jeopardize the very existence of the partial hospitalization benefit itself.

JMBHC is a member of The Association of Ambulatory Behavioral Healthcare (AABH) and we support their response to this situation which is as follows:

1. Re: CMS methodology utilized to calculate the current proposed rates, on Page 255 states □We use CCRs from the most recently available hospital and CMHC cost reports□. The costs utilized are at least 1 to 3 years old and are used to project rates 2 years forward. A review of the data utilized for the CY 2008 rates would indicate that as much as 50% of the cost data could be 3 years old from 2004. Page 255 of the report goes on to say that □All of these costs are then arranged from lowest to highest and the middle value of the array would be the median per diem cost□. This process guarantees that 50% of the providers will be providing

services and be receiving reimbursement below their daily costs. Combining cost data several years old with recent units of service does not accurately reflect the costs the providers endure.

2. CMS has identified the true Median Cost of APC 325 for group therapy at $66.17. With a minimum of 4 services per day (we offer 5 programs), CMS would recognize the minimum cost at $264.68 per day. These data are inconsistent with a rate of $179.88.

3. Unlike the other 1100+ APC codes which generally represent individual medical procedures,

PHP is a complete service industry, that encompasses a complete business setting rather than one simple process such as a Corneal Transplant (0244). There is precedent in other CMS OPPS service industries to exclude the services from the APC code listing and treat them independently. Home health was just finalized for CY2008 with a set rate and a 3 percent increase if certain quality data standards are met or a 1 percent increase if the standards are not met. PHP could be treated the same. This would stabilize the rates and generate future rate predictability for these services.

4. The CMS table on p. 257 of CMS-1392-p reflects 4 median per diem costs as determined by CMS. The projected rate of $179.88 is the lowest of the four samples. This would penalize all CMHCs providing four or more units of service per day. All current PHP LCD□s of the Fiscal Intermediaries state the CMS requirements that □Partial Hospitalization Programs must offer a minimum of 20 hours a week of structured program provided over at least a five-day period.□ The minimum patient participation is three hours per day of care with a minimum of 12 hours per week.□ AABH would offer 2 suggestions. First, enforce the minimum service requirement to assure PHPs are offering at least 20 hours of structured programming per week. Second, days of service with less than 4 services are being paid within the rules of CMS and Medicare. Programs should not be penalized for following the rules.

We recommend that CMS take the following course of action:

1. Allow the PHP per diem to remain the same as the CY2007 per diem rate of $234.73.

2. JMBHC encourages CMS to go with AABH to the legislature and support a legislative amendment to:

Remove PHP from the APC codes and have independent status,
Establish the current rate of $234.73 as the base per diem rate,
Annually adjust the base rate by a conservative inflation factor,
Establish quality criteria to judge performance and that influences future rate reimbursement.
Respectfully, Randi Hackbarth, RN,MPA, CNA
Dir. Of Nursing JMBHC

CMS-1392-P-687 **Medicare**

Submitter : Dr. saiah florence **09/11/2007**

Organization : Dr. saiah florence
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

please review our comments in making your decision on the above issues.

CMS-1392-P-688 **Medicare**

Submitter : kathi lencioni **09/11/2007**

Organization : Sharp Mesa Vista Hospital
Individual

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

We strongly opposes CMS□ proposed cuts to PHP, and urges the agency to re-consider its ongoing rate cuts to ensure adequate beneficiary access to PHP services. Further, we suggest that CMS consider providing differential per diem payments based on the setting and intensity of services provided during the PHP day. PHP care is intensive outpatient care which allows seniors individuals to remain in their community while receiving needed mental health care, an important aspect of community-based care models. Moreover, PHP is widely regarded as a substitute to inpatient psychiatric hospitalization, which tends to be more expensive for Medicare and more disruptive to beneficiaries. Cuts to PHP, especially cuts of this magnitude have real potential to curtail provision of this much needed, cost effective, community based alternative to hospitalization. The proposed cuts would affect beneficiary access not just to PHP, but to other outpatient mental health programs, and may prompt more inpatient hospitalization, thus increasing costs to the Medicare program.

CMS-1392-P-689 **Medicare**

Submitter : Mr. Jeffrey Fields **09/11/2007**

Organization : UNM Hospital
Other Technician

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

Regarding the proposal to eliminate separate payment for contrast agents used in echocardiograms performed in hospital outpatient settings in 2008, please consider this: I only use contrast when indicated. It doesn't make sense otherwise. If there is a financial disincentive to not use contrast, doctors will order more expensive invasive procedures that are frequently proven unnecessary by contrast. In addition to this, contrast is costly and the expense should not be passed on to patients not in need of it. Please reconsider by considering the patient.

Thankyou.
Jeffrey Fields
Cardiac Sonographer

CMS-1392-P-690 **Medicare**

Submitter : Ms. SHIRLEY DILKS **09/11/2007**

Organization : NONE
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

Dear Mr. Weems:
Regarding: CMS-1392-P, OPPS: Packaged Services

I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with (cervical & oralmandibular dystonia), (dystonia is a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMSs proposal to bundle the payment rate to hospitals for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. Both the guidance service and the botulinum toxin injections I receive are critically important for my ability to function normally and have relief of the pain associated with dystonia.

I respectfully request that CMS not package the payment of these services together but continue to pay for them separately. The proposed change may result in hospitals pressuring doctors not to utilize this equipment and the injections being ineffective because it does not get to the right muscles to have benefit for me. The guidance service is critically important for this treatment to be effective.
Thank you for allowing me to provide these comments.

Sincerely,
Shirley Dilks

CMS-1392-P-691 **Medicare**

Submitter : none none **09/11/2007**

Organization : none
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with Meige Syndrome,a type of dystonia (a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS's proposal to reduce the payment rate to hospitals and/or physicians, for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. These injections are critically important to my ability to function normally.

I respectfully request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have two few knowledgeable injectors in the first place. Anyone can inject botulinum toxin. Not just anyone can inject it successfully to relieve the spasms. Also, this change in policy would destroy the uniformity of payments made across settings that ensures there are no economic rewards or penalties to providers, depending on where the injections are given.

Thank you for allowing me to provide these comments.

Sincerely, a sufferer of Meige Syndrome, currently receiving Botox injections from my neurologist

CMS-1392-P-692 **Medicare**

Submitter : Dr. UDAY BHATT **09/11/2007**

Organization : PAIN MANAGEMENT
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

September 10, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS□1392□P, Mail Stop C4□26□05
7500 Security Boulevard
Baltimore, MD 21244□1850

Re: CMS-1392-P

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the Proposed Rule CMS-1392-P, □Proposed Changes to the Hospital Outpatient Prospective Payment System (HOPPS) and CY 2008 Payment Rates□ (the Proposed Rule) published in the Federal Register on August 2, 2007. My comments cover two main issues related to the HOPPS and ambulatory surgery center (ASC)

payment methodologies.
I. ASC Procedures

There are several specific procedure issues we ask CMS to review and address. I believe that two procedures that have not been included on the ASC payment list, but that are paid under the HOPPS and should also be included on the ASC list. These procedures are described by CPT codes 22526 (percutaneous intradiscal electrothermal annuloplasty, single level) and 22527 (percutaneous intradiscal electrothermal annuloplasty, one or more additional levels). There is no reason why

ASCs should not be entitled to payment for these two procedures. The procedures are safely done in ASCs, and they are not procedures routinely performed in a physician□s office. I ask CMS to include both procedures on the ASC list in the final rule.

ASIPP also is concerned that procedures 72285 (discography - cervical or thoracic - radiological supervision and interpretation) and 72295 (discography □ lumbar - radiological supervision and interpretation) have been packaged in all circumstances under the ASC proposed rule. These services are payable separately in the HOPD in certain circumstances and I believe the same should be true for ASCs.

Lastly, I ask CMS recalculate the payment rate of CPT code 64517. The proposed payment rate for this procedure is $178 for CY 2008. While I do recognize that the payment for the procedure following the transition period will be $295, a payment of $178 seems too low.

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I ask that CMS create a new APC for implanting rechargeable neurostimulators upon expiration of the new technology transitional pass-through payment at the end of 2007.

I am concerned that the CMS proposal to pay rechargeable and non-rechargeable neurostimulator procedures under the same APC (0222) ($12,314 in hospital outpatient departments and $10,925 in ASCs) will impair Medicare Beneficiaries access to neurostimulation therapy utilizing rechargeable devices. The proposed payment structure could lead to such financial pressures on the facilities purchasing these devices and ultimately cause the restrictive use of this technology despite the fact that rechargeable devices represent a

major improvement in neurostimulation therapy for patients with chronic pain. If access to the rechargeable technology is inhibited than Medicare beneficiaries in need of this type of treatment for chronic pain will be relegated to non-rechargeable technology and subject to the risks and co-insurance costs associated with repeat surgical procedures for battery replacement. This outcome seems inconsistent with CMS□s own determination that this technology offers beneficiaries substantial clinical improvement over non-rechargeable implantable which was evidenced by the decision to grant rechargeable implantable neurostimulators new technology pass-through payments for 2006 and 2007.

Implantable neurostimulators ensure that chronic pain patients have consistent pain control without interruption. The clinical benefit of the first generation non-rechargeable neurostimulator technologies is limited by the need for repeat surgical procedures for battery replacement any where from every two to four years depending on the usage of the device. Unfortunately, what we know from experience is that many physicians using non- rechargeable battery devices will utili

CMS-1392-P-693 **Medicare**

Submitter : Dr. Mukesh Parekh **09/11/2007**

Organization : Dr. Mukesh Parekh
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

Focused Ultrasound Ablation of Uterine Fibroids with Magnetic Resonance Guidance (MRgFUS) This will revolutionize the treatment from surgical management to nonsurical management.

OPPS: Packaged Services

OPPS: Packaged Services

I am requesting CMS to consider assignment of 0071T and 0072T to APC 0127. Which does more accurately reflects the clinical and economic resources utilized.

CMS-1392-P-694 **Medicare**

Submitter : Dr. Janice labranche **09/11/2007**

Organization : Exablate of Phoenix
Physician

Category :

Issue Areas/Comments

Physician Paymen Services Provided in ASCs

Physician Paymen Services Provided in ASCs

I request that the services of MRFUS treatment of uterine fibroids be reimbursed appropriately as the time spent in planning, preparation, treatment and followup of each patient is very time intensive. This is a very important option in women's health care and deserves to be regarded as such. The current figures for reimbursement are too low considering all the above and a fare payment would be twice that figure. I look forward to continuing to provide this treatment option for women who more often desiring this option.

CMS-1392-P-695 **Medicare**

Submitter : Dr. Amr Zidan **09/11/2007**

Organization : UT Southwestern
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-1392-P-695-Attach-1.DOC

#695

September 10, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1392–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1392-P

Dear Mr. Kuhn:

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Implantable neurostimulators ensure that chronic pain patients have consistent pain control without interruption. The clinical benefit of the first generation non-rechargeable neurostimulator technologies is limited by the need for repeat surgical procedures for battery replacement any where from every two to four years depending on the usage of the device. Unfortunately, what we know from experience is that many physicians using non-rechargeable battery devices will utilize program settings that require less power in order to conserve the life of their non-rechargeable battery. This practice compromises the patient's opportunity to obtain optimal pain relief on a day-to-day basis; but patients choose this option as opposed to undergoing another surgical procedure. Rechargeable neurostimulators are capable of delivering continuous stimulation, even at high levels, to optimize patient relief without concern of rapid battery depletion.

Approximately 25 to 30 percent of all the neurostimulator implant procedures performed each year are required to replace a depleted, non-rechargeable battery. Thus, in the long term, the use of rechargeable devices likely would result in cost savings to the Medicare program and beneficiaries due to the decreased need for battery replacement procedures. The need for fewer surgeries also would reduce the chances that patients will experience operative complications such post-operative infection or other possible co-morbidities.

I ask CMS to create an APC for procedures using rechargeable implantable neurostimulators that is separate and distinct from the proposed APC grouping (0222) to create greater resource consistency. While we appreciate that CMS wants to bundle similar procedures that may utilize a variety of devices with different costs, it is inappropriate to bundle procedures when the absolute difference in cost is so significant. CMS's own analysis of the claims data associated with APC 0222 (shown in Table 35 of the preamble) reveals significantly higher costs for procedures associated with rechargeable neurostimulators ($18,089 median cost) than non-rechargeable neurostimulators ($11,608 median cost).

While I recognize the difference in median costs does not create a two times rule violation, the difference in median cost is not insignificant. CMS has assigned pass-through devices to a new APC or to a different, existing APC in absence of a "two-times" rule violation and for median costs differences significantly less than $1,000. I urge CMS to take a similar approach here. The creation of two separate APCs would result in more appropriate payment for both types of procedures—rechargeable and non-rechargeable neurostimulator procedures—based on their relative costs. To implement our recommendation, we further recommend that CMS create a G-Code to distinguish between implanting a rechargeable and a non-rechargeable neurostimulator.

Moreover, ensuring the payment rate is appropriate under the HOPPS system will result more appropriate payment in the ASC setting. Today, ASCs receive reimbursement for rechargeable generators through the DMEPOS fee schedule (L8689- rechargeable generator). With the current proposal ASC reimbursement will be based on 100% of the device component and approximately 65% of the service component of the APC payment. If the device component, as determined from the OPPS claims data, is based on a mix of rechargeable and non-rechargeable device costs, payments to ASCs will vastly underpay for the actual equipment, which costs the same in all

settings. Now that the two payments systems are inextricably linked it is even more incumbent upon CMS to ensure that payments are adequate under the HOPPS or Medicare beneficiaries may be left without an option to have this procedure performed at a HOPD or an ASC.

In summary my recommendations to CMS are:

- Create a new APC for procedures using rechargeable neurostimulators to recognize the full device and facility costs associated with these procedures.
- Establish new HCPCS II "G-codes" to differentiate between rechargeable and non-rechargeable neurostimulators.
- Alternatively, CMS could continue using the device C-code, C-1820, to assign rechargeable neurostimlutor procedures to a new APC.
- Maintain non-rechargeable neurostimulator procedures in APC 0222.

***

Thank you for your consideration of my comments.

Sincerely,

Amr Zidan, MD

1220 Backbay Drive

Irving, TX 75063-5408

CMS-1392-P-696 **Medicare**

Submitter : Dr. R. Mark Turner **09/11/2007**

Organization : Dr. R. Mark Turner
Physician

Category :

Issue Areas/Comments

New HCPCS and CPT Codes

New HCPCS and CPT Codes

September 11, 2007

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1392-P (Hospital Outpatient Prospective Payment System)

Comment Reference: Focused Ultrasound Ablation of Uterine Fibroids with Magnetic Resonance Guidance (MRgFUS)

Dear Deputy Kuhn:

As a practicing gynecologic oncologist in Las Vegas, Nevada. I am pleased that the CMS has offered me the opportunity to comment on the proposed rule regarding changes to the Medicare hospital outpatient prospective payment system. MR guided Focused Ultrasound (MRgFUS) has the potential to radically change the face of medicine relative to treatment options for symptomatic uterine fibroids. Recognizing the potential benefit to patients I am proud to be among the leading physicians offering this technology to women with painful fibroids. It appears clear that this

technology has tremendous potential to successfully treat such patients with minimal inconvenience to these women both in terms of discomfort and time away from family and professional obligations.

I am grateful for CMS proposal to move the CPT procedures for MRgFUS (0071T and 0072T) into APC 0067 with a proposed payment of $3,918.43 and the recognition that it belongs with other image guided therapies. It shares many similarities with these procedures both clinically and in terms of resources required:

1) Treatment objective is non-invasive tumor destruction
2) The surgery is conducted using an external source of energy which penetrates into the body to reach the tumor
3) Imaging technology is required
4) Extensive treatment planning is involved with continuous monitoring during treatment
5) Expensive capital equipment in dedicated specialized treatment rooms
6) Lengthy procedure time ranging from 2-5 hours

However the payment rate for this procedure continues to be far below the costs incurred to provide this service and does not reflect the treatment planning component that is required to perform the MRgFUS procedure.

I recommend that CMS consider assignment of 0071T and 0072T to APC 0127, Level IV Stereotactic Radiosurgery, which would permit appropriate payment for the extensive treatment planning. Level IV Stereotactic Radiosurgery assignment would permit MRgFUS to be classified into an APC with similar clinical and resource homogeneity.

The MRgFUS procedure provides excellent clinical results in a cost effective manner and should be assigned to an appropriate APC that permits hospitals and outpatient centers to offer this less invasive procedure option to patients with uterine fibroids. We urge CMS to reassign HCPCS codes 0071T and 0072T to APC 0127 which more accurately reflects the clinical and economic resources utilized.

Thank you for the opportunity to provide comments to the proposed rule for hospital outpatient services in 2008.

Respectfully,

R. Mark Turner
517 Rose Street

Las Vegas, Nevada
89106