



August 28, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1413-P
P.O. 8013
Baltimore, MD 21244-8013

RE: CMS-1413-P – Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

Dear Administrator Frizzera:

The Society for Vascular Surgery (SVS), representing over 2,600 practicing vascular surgeons in the United States, offers the following comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule Proposed Rule for Calendar Year (CY) 2010.

Physician Fee Schedule (PFS) Update for CY 2010

SVS would like to commend CMS for recognizing the disproportionate growth in expenditures for physician-administered drugs. SVS supports the CMS proposal which will effectively remove physician-administered drugs retroactively to the 1996/1997 base year of the Sustainable Growth Rate (SGR) formula. SVS has worked with other medical societies over the past several years to urge CMS to use its administrative authority for this purpose. This change will lessen the discrepancy between actual and target expenditures resulting in a reduction in the future projected physician payment cuts. The AMA projects that removal of these costs restores approximately \$130 billion to physician services. Until Congress replaces the SGR formula with a system that reflects actual physician practice costs, this proposed action by CMS is imperative if we are to have any hope of adequate physician payments in the future.

Practice Expense Proposals for CY 2010

- **Use of Physician Practice Information Survey (PPIS) for CY 2010**

SVS has long believed that CMS should use the most current data regarding the practice expense costs required to provide services for diagnosis and treatment of vascular disease. The AMA PPIS allows for data to be updated for all medical specialties at the

same time, while using the same instrument, and same criteria for gathering and submission of this data. Also, we appreciate that CMS used the same organization to validate this new AMA PPIS data as they did with the prior supplemental survey data.

Therefore, SVS would urge CMS to move forward with its proposal to use the AMA PPIS data in calculating the practice expense RVUs in CY 2010. With the cost of clinical support staff increasing annually and the overhead costs to operate a practice skyrocketing, it is important that CMS be able to incorporate these increases in costs in a timely fashion.

- **Equipment Utilization Rate**

SVS supports CMS' proposal to increase the utilization rate from 50% to 90% for equipment priced over \$1 million. This CMS proposal is in keeping with the recommendations from the RUC. However, the RUC also stated and SVS agrees that if a specialty society can produce data to support a lower utilization rate, CMS should consider their argument in a case by case basis.

Malpractice RVUs

Having participated in the various discussions regarding how to calculate malpractice RVUs for the technical component (TC) of imaging codes, SVS appreciates CMS' effort to find a logical and reasonable methodology. CMS is right to assume that there are malpractice costs incurred by a vascular surgeon's practice for their non-MD staff. Also, CMS is correct in making the assumption that these premiums would never come close to the cost of malpractice premiums paid by the vascular surgeon. The proposed fee schedule has changed the malpractice RVU content for the TC services to zero. In the case of non-invasive vascular studies, a certified technologist is required to produce an adequate and meaningful assessment. SVS believes that the work of this technologist is subject to some degree of professional liability risk separate and distinct from the professional fee associated with the interpretation of the examination. SVS believes that this risk is not zero and requests that CMS reconsider the complete removal of all malpractice RVUs from TC services in the CY 2010 PFS final rule. We agree that the current TC malpractice RVUs may be too high, but dropping them to zero certainly misses the mark of accurate resource allocation on the low side.

SVS would be happy to work with CMS regarding this proposed malpractice RVU algorithm as it continues to refine it over time. We understand that some thoughtful methodologies are under consideration.

Payment for the Initial Preventive Physical Examination (IPPE)

SVS supports the reimbursement increase for an IPPE to the equivalent of a level four new patient office evaluation as one way to encourage physicians to offer this service to Medicare beneficiaries within the first twelve months after the date of the beneficiaries'

enrollment in Medicare Part B. However, another deterrent continues to be the onerous paperwork that must be completed by physicians when this service is performed. We recommend that CMS continue to streamline this aspect of the service in order to remove barriers that deter a physician from performing the IPPE and thereby prevent appropriate referral for linked screening such as that for abdominal aortic aneurysm.

The utilization rate for the one-time abdominal aortic aneurysm (AAA) ultrasound screening for at-risk Medicare beneficiaries remains low because the ultrasound screening examination is linked to the IPPE. SVS believes that CMS has not done enough to promote the IPPE nor the AAA screening. SVS again requests that CMS use all available financial resources to promote these benefits, both to physicians and beneficiaries, similar to the effort CMS made to promote the Part D prescription drug benefit.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting Initiative (PQRI)

SVS has supported the PQRI program since its inception and has been active in creating consensus-based quality measures that have been approved by the National Quality Forum (NQF). We are pleased that on a voluntary basis, our members will be able to receive a 2% incentive payment of their estimated total allowed charges in 2010 for successfully reporting three measures in at least 80% of the applicable cases.

We understand that measures can be reported by one of three methods: claims based, registry and electronic health records. SVS continues to support the use of registries as a recognized instrument to leverage existing clinical data collection efforts. Although not available for CY 2010, we are exploring the possibility that the SVS carotid stent vascular registry will be able to act as a data submission vendor and will look forward to working with CMS to hopefully make this happen by CY 2011.

Another positive development is the acceptance of quality measure data extracted from electronic health records for a limited subset as a third manner of PQRI reporting. The availability of three methods should allow more vascular surgeons to participate in the program. The new measures' groups that have a particular clinical condition or focus in common, such as perioperative care, should also help expedite the reporting of quality measures.

In addition, although there are plenty of measures for vascular surgeons to report, we strongly support the continued development of risk-adjusted outcomes measures vs. process measures as true measures of physician quality.

SVS does have concerns regarding the public reporting of participation data. Consumers must be made aware that non-participation in this voluntary program does not indicate that a physician or surgeon provides low quality care. SVS urges CMS to use extreme caution in publicizing the names of successfully reporting physicians – this public reporting should not be characterized as comparative quality data. We would remind

CMS that MIPPA only authorizes CMS to post on the Internet the list of names of eligible professionals who satisfactorily submit data. Thus, CMS currently does not have the statutory authority to publicly report performance data gathered under PQRI.

PQRI continues to be a voluntary program with low participation; there are many reasons that physicians might not participate in the program and these have nothing to do with the quality of care they provide. For example, some academic medical centers already have intensive quality improvement programs in place. PQRI would add cost and administrative burden that would detract from their existing programs and thus physician reporting through the PQRI mechanism has not been adopted.

Finally, two complaints SVS has received are the length of time it takes CMS to inform physicians that they did not successfully report and the lack of explanation regarding why they did not successfully report. We urge CMS to solve these two problems before the 2010 program begins.

Consultation Services

In general, SVS supports CMS' proposal to no longer recognize the billing codes for consultation services. We agree with CMS that there has been confusion and conflict between the Medicare requirements for billing a consultation code and the CPT requirements for billing a consultation code.

However, if CMS is to move forward and implement this change, we would urge that CMS make corresponding updates to global procedures to account for the proposed increases in the office visit codes. Arbitrarily changing the work RVUs for some Evaluation and Management (E/M) codes without adjusting the E/M components of other procedural codes (e.g., 90 day and 10 day global procedures) undermines the relative value scale on which physician payment is based. In the most recent five year review when office visit codes were increased, CMS did adjust the E/M components of other procedural codes assigned 10 day and 90 day global periods to maintain the integrity of the relative value system.

Furthermore, SVS has concerns about how this change in Medicare billing and payment practices might affect the billing and payment practices of third-party/commercial payers and how it would impact electronic medical records, and the standardization of the various types of billing forms, requirements, etc. of the various insurance companies. We would ask that CMS work with its colleague in the commercial payer community and also with the HHS communities that are working on implementation of health information technology standards to harmonize these billing requirements.

Finally, physicians must have the ability to track Medicare consultative services for any quality related activities. We would ask that CMS address these issues in the Final Rule.

Misvalued CPT Codes

SVS requests that CPT codes 34830, 34831 and 34832, concerning open repair of infrarenal abdominal aortic aneurysm or dissection, plus repair of associated arterial trauma following unsuccessful endovascular repair, allow for assistant at surgery billing with modifier-80 or -82. The endovascular aneurysm repair CPT codes (34800, 34802, 34803, 34804, and 34805) allow for assistant at surgery billing. The main open aortic aneurysm CPT codes (35081, 35091, and 35102) allow for assistant at surgery billing. SVS believes that open repair after a failed attempt at endograft (where the surgeon may have spent over 4 hours unsuccessfully on the endograft portion) represents a more complicated endeavor. As such, an assistant at surgery in this setting is appropriate and should be properly compensated.

Review of Services Often Billed Together

SVS appreciates CMS recognizing the work of the RUC on reviewing those CPT codes that are often billed together. Again, we feel that the current RUC criteria which require services billed together 90 percent or more of the time on the same day for the same patient for the same indication for them to be considered for a payment efficiency policy is most appropriate. CMS has proposed to lower this threshold to 75 percent. Such a change could force certain procedures which provide higher quality, lower cost care, such as non-invasive vascular studies, to be abandoned in favor of more expensive, invasive procedures that have greater risk and would be performed on a different day from other procedures for that indication.

23 Hour Stay

Surgeons performing operations that require 23-hour stays provide substantial and necessary evaluation and management service to those patients throughout the day of surgery. This occurs in addition to the immediate post-op period. SVS is pleased that CMS recognizes the extra effort required for these 23-hour stay patients, but we are concerned that adding minutes rather a visit forces a substantial discount for the surgeon's work. By the original Stone formula for calculating global surgical packages, immediate post-op work is reimbursed at 0.0224 RVUs per minute. This represents a 44% discount compared to the 0.040 RVUs per minute currently associated with inpatient hospital visit 99231. SVS requests that the Agency allow addition of an appropriate visit on the evening of the 23-hour stay. If this is not acceptable, we request that the assigned additional minutes be reimbursed at par with inpatient hospital day 99231 which is now approximately 0.040 RVUs per minute.

It is also important to point out that with 23-hour stay patients, discharge services provided during the day after surgery may well require a full 99238 rather than the 0.5 99238 routinely assigned to patients who go home on the day of a hospital outpatient procedure. We are not suggesting that every CPT service that typically requires a 23-hour stay should be assigned a full 99238, but we do believe there are certain cases performed in individuals with multiple comorbidities that, in the typical patient, would justify assignment of a full 99238.

Establishing Appropriate Values for Physician Fee Schedule Services

CMS is requesting public comment on the concept of an expert panel separate from the RUC to ensure that the relative valuation within the Resource-Based Relative Value Scale (RBRVS) is appropriate. SVS has been a long and active member of the RUC, providing information and expertise regarding the appropriate valuation of CPT codes that represent all types of services provided to patients with known and suspected vascular disease.

Also, SVS members have been active participants in numerous RUC committees and workgroups, including the workgroup that developed recommendations for the monthly payments for the Medical Home Demonstration and the workgroup that helps identify potentially mis-valued services. We believe the RUC has the technical knowledge and objective judgment to best assist in the maintenance of RBRVS. SVS believes that creating an additional external review body that comes between the work of the RUC and the work of CMS in utilizing the RUC's results would be redundant and a waste of government resources.

Accreditation Standards for Suppliers Furnishing the Technical Component of Advanced Diagnostic Imaging Services

CMS plans to implement section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) (“MIPPA”), which preconditions Medicare payment for the TC of “advanced diagnostic imaging services” on the supplier being accredited by an accreditation organization designated by the Secretary. We believe that the accreditation requirement will help ensure that high quality and safe MRI, CT, and other advanced imaging services are provided to Medicare beneficiaries.

SVS has advocated requiring accreditation of noninvasive vascular laboratories to ensure similar high quality, safe diagnostic vascular studies for the Medicare patient. SVS strongly believes that accreditation is particularly important with respect to the proper performance of vascular ultrasound studies because our members commonly see studies referred from non-accredited laboratories that are significantly suboptimal or frankly inaccurate. This has been documented in peer reviewed literature published over the past decade. Improper performance of a vascular ultrasound study may significantly adversely impact the quality of care provided to Medicare beneficiaries.

We understand that MIPPA speaks only to advanced diagnostic imaging services, but we request that CMS use other sources of regulatory authority to establish laboratory accreditation requirements for the performance of vascular ultrasound services.

SVS appreciates the opportunity to provide comments on this proposed rule. If you have any questions or need additional information, please contact Pamela Phillips, Director of Health Policy and Government Relations, at pPhillips@vascularsociety.org or 703-573-7894.

Sincerely,

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