August 24, 2010

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1503-P - Medicare Program; Payment Polices under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2011

Dear Administrator Berwick:

The Society for Vascular Surgery (SVS), a professional medical society composed of 3370 specialty-trained vascular surgeons and other medical professionals who are dedicated to the prevention and cure of vascular disease, respectfully offers the following comments on the Centers for Medicare & Medicaid Services' (CMS) Medicare Physician Fee Schedule (PFS) Proposed Rule for Calendar Year (CY) 2011.

Highlights of Letter

- **Recommend removal of the referral requirement in the Initial Preventive Physical Exam for abdominal aortic aneurysm (AAA) screening, thus making the one-time screening also available in the Annual Wellness Visit;**
- **Regarding the waiving of the deductible or coinsurance for preventive services, support no modification to any current Medicare policies where a preventive service is already covered for a certain population even though it does not have a grade of A or B from the USPSTF;**
- **Support a permanent solution for how physicians are paid by Medicare;**
- **Support the convening of a technical advisory panel to review all aspects of the Medicare Economic Index before it is rebased and revised;**
- **For the Physician Quality Reporting Program (PQRI), support lowering the threshold for reporting from 80 percent to 50 percent of applicable cases, defining groups as two vs. 200, using registries as a recognized instrument for reporting, assuring timely feedback and establishing an appeals process;**
- **PQRI concerns include: onerous requirements for receiving a 0.5 percent incentive payment for participating in maintenance of certification programs, lack of risk-adjusted outcomes measures, Physician Compare web site and penalties imposed on physicians who do not successfully report PQRI measures in CY 2015;**
- **Agree that the AMA/Specialty Society Relative Value Update Committee (RUC) has made significant progress in addressing potentially misvalued services;**
- **Concerned with consolidation of some individual services into bundled codes for payment under the PFS and the resulting non-facility reimbursement for multiple**

vessel endovascular interventional therapy using the current multiple procedure discount of 50 percent;

- **Request for a second time that open repair of infrarenal AAA or dissection, plus report of associated arterial trauma following unsuccessful endovascular repair allow for assistant at surgery billing;**
- **Agree that physician services related to the post-procedure services during a 23-hour stay be properly recognized;**
- **Recommend a full CPT 99238 for appropriate 23-hour stay patients;**
- **Oppose CMS overriding codes that RUC has already classified as 23+ hour codes;**
- **Concerned that CMS is proposing to update high-cost supplies on data from a pricing schedule that is administered by the VA, which does not represent prices available to non-VA providers and their practices;**
- **Recommend that CMS continue to use independent contractors in conjunction with physician specialty societies to develop prices for high-cost supplies and consider establishing J-codes;**
- **Concerned with applying Multiple Procedure Payment Reduction to multiple imaging services furnished within the same family of codes or across families – will create disadvantages for the use of imaging modalities that have lower reimbursement such as ultrasound;**
- **Recommend that CMS work with medical specialty societies in the creation, validation and testing phases regarding the method and software to be used for group episodes of care for Medicare beneficiaries with chronic conditions;**
- **Request that CMS use a broad group of physicians, including surgeons, to validate and test the software;**
- **Appreciate that CMS is implementing a 10 percent incentive payment to general surgeons in shortage areas with new funding, but would like to remind CMS that vascular surgery has one of the most severe manpower shortages of any physician specialty, including primary care and general surgery;**
- **Support not including radiology or imaging services such as ultrasound in the new disclosure requirement for in-office ancillary services;**
- **Concerned that the proposed reporting threshold of 25 visits for the e-prescribing incentive payment is too high for vascular surgeons;**
- **Recommend that CMS define a successful electronic prescriber on a specialty-specific basis;**
- **Recommend that the financial penalties for lack of e-prescribing be in 2012, not 2011, which is consistent with law.**

Proposed Implementation of Section 4103 of the Accountable Care Act (ACA): Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

Elements of a Personalized Prevention Plan

The SVS is encouraged with the methods that CMS is proposing to implement the personalized prevention plan as required by the ACA, including the need for a written check list of an individual's screening schedule. We agree with CMS that it is important this written schedule contain a comparative list of individuals' health status, risk factors, personal and family history along with the screening and preventive services they should be receiving for the next 5-10 years using a method, such as a "check-box", to ensure that screening and preventive services were obtained in a timely manner, instead of waiting for an entire 12 months to verify that they were

received. We believe it is important that this check list contain not only those services that Medicare covers, but also services that may be appropriate for individual patients, regardless of coverage status. Insurance coverage alone should not be the deciding factor regarding whether a screening or preventive service should be discussed with a patient.

With regard to the documentation of the list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or underway, the SVS would ask that CMS specifically mention the need to document active or previous history of smoking and the recommended action to address such situation, given the impact of smoking or a history of smoking regarding whether an individual will suffer a AAA or some other type of cardiovascular disease. Also, we believe an individual's family history of vascular disease should be explicitly listed under "risk factors". Family history is an important predictor and needs to be documented in an individual's personalized prevention plan.

Ensure Access for Medicare Beneficiaries to AAA Screening

The SVS supported the original Screening Abdominal Aortic Aneurysms Very Efficiently (SAAAVE) Act, which was enacted into law as part of the 2005 Deficit Reduction Act and became effective on January 1, 2007. This law provides a one-time ultrasound screening for at-risk Medicare beneficiaries, including men who have ever smoked and men and women with a family history of AAA, as part of the Initial Preventive Physical Exam (IPPE). As you are aware, screening for AAA is endorsed by the United States Preventive Services Task Force (USPSTF). At the time this screening benefit was enacted, it was felt that if utilized, the new law could prevent over 15,000 deaths each year from ruptured AAAs based on American Heart Association statistics.

Because AAA screening is tied to the IPPE, which is only available during the first year of Medicare eligibility, many at-risk beneficiaries are not getting screened. Less than 10,000 beneficiaries were screened in 2007, approximately 18,000 in 2008 and 20,000 in 2009. The requirement of a referral during the IPPE is not consistent with the USPSTF recommendation, which states the clinical need as being a one-time screening for at-risk individuals; it does not state that this screening must occur during the first 12 months that an individual is a Medicare beneficiary.

In fact, given the proposed relationship between the IPPE and the new Annual Wellness Visit, it could be determined that beneficiaries need a screening for AAA during their Annual Wellness Visit, but not have coverage for that screening because a referral was not made as part of an IPPE that occurred during the first 12 months of Medicare eligibility. Thus, it is very likely that Medicare beneficiaries will not have access to this simple, non-invasive, effective test unless they pay for it.

Therefore, the SVS urges the Health and Human Services (HHS) Secretary to use the new authority granted as part of Section 4105 – Evidence-Based Coverage of Preventive Services in Medicare of the ACS to remove the requirement of a referral as part of the IPPE being necessary for Medicare beneficiaries who are at risk – men who have ever smoked and men and women with a family history of AAA – to receive their one-time screening for AAA. With the advent of the personalized prevention plan, the occurrence of this one-time screening can be easily verified and thus not duplicated.

Section 4105 states that "Notwithstanding any other provision of this title, effective beginning January 1, 2010, if the Secretary determines appropriate, the Secretary may

(1) modify--
   (A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force;

As stated earlier, the referral requirement under the IPPE for a Medicare beneficiary to receive a AAA screening was not a requirement of the USPSTF recommendation. This is also consistent with the new private insurance regulations on prevention and wellness, in which AAA screening is included without the need for a referral.

Again, we urge the HHS Secretary to take action to remove this referral requirement as it is estimated that over one million Americans have AAAs and at least 95 percent of these can be successfully treated if detected prior to rupture. But because AAAs are almost always asymptomatic, the problem largely goes undetected and untreated, leading to needless loss of life.

Proposed Implementation of Section 4104 of the Accountable Care Act (ACA): Removal of Barriers to Preventive Services in Medicare

Deductible and Coinsurance for Preventive Services

The SVS supports CMS's proposal to waive the deductible and coinsurance for any Medicare-covered preventive service recommended with a grade of A or B for any indication or population, with no limits as long as the USPSTF has recommended the preventive service for at least one indication and/or population with a grade of A or B.

We appreciate that for the purposes of waiving the deductible or coinsurance, CMS is not modifying any current Medicare policies where a preventive service is already covered for a certain population, but does not have a USPSTF grade of A or B. We believe CMS is correct in relying on physicians to order preventive services that are clinically appropriate for specific beneficiaries.

The removal of financial barriers to screening and preventive services in the form of deductibles and coinsurance is an important way to expand access to these services. Using AAA screening as an example, Medicare pays for an inexpensive screening for those at-risk instead of a six-figure pay out for repair of ruptures and subsequent rehabilitation and loss of productivity, assuming that these ruptures do not cost the Medicare beneficiaries their lives.

CY 2011 Physician Fee Schedule Update/Rebasing and Revising of the Medicare Economic Index (MEI)

When the Sustainable Growth Rate (SGR) law that temporarily replaced the 21 percent cut to Medicare physician payment for six months with a 2.2 percent increase expires on December 1, 2010, physicians face a 23 percent reduction and an additional 6 percent reduction would be applied beginning January 1, 2011 in the absence of congressional action. The SVS continues to strongly oppose short term fixes and basing physician payment updates on the SGR. A permanent solution is needed for how physicians are paid by Medicare.

The proposed rule estimates that the 2011 MEI will be a .3 percent increase in practice costs. We support rebasing and revising the MEI to reflect appropriate physician expenses as proposed by

CMS, but are concerned that 2006 data collected in the Physician Payment Information Survey will be used to make the revisions. This data will likely not reflect appropriate physician expenses in 2011. We also support removing all costs for drug expenses as was done for the SGR formula last year and commend CMS for proposing this change.

In addition, we support a provision in the proposed rule for the convening of a technical advisory panel to review all aspects of the MEI. Our recommendation is to convene this panel before major changes are made to the MEI, since it will be reviewing how inputs, input weights, price-management proxies and productivity adjustments are relevant to current physician practices.

CY 2011 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. We are pleased that on a voluntary basis, our members will be able to receive a one percent incentive payment of their estimated total allowed charges in 2011 for successfully reporting three measures and a .5 percent incentive payment for participating in maintenance of certification (MOC) programs. However, we believe the requirements for receiving a MOC payment are too onerous for both physicians and MOC boards and should not be tied to successfully reporting PQRI measures.

We also appreciate that the threshold for reporting has been lowered from 80 percent to 50 percent of applicable cases, which should allow more vascular surgeons to successfully report, qualifying them for incentive payments. In addition, defining groups as two vs. 200 should allow additional vascular surgeons to participate in the program.

We understand that measures can be reported by one of three methods: claims-based, registry and electronic health records. SVS supports the use of registries as a recognized instrument to leverage existing clinical data collection efforts. Although not available for CY 2011, we continue to explore the possibility that the SVS carotid procedures 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 in CY 2012.

Two other positives are the assurance of timely feedback and the establishment of an appeals process. Both of those issues were included as problems in the SVS comments on the CY 2010 proposed rule, so we thank CMS for recognizing the need for improvement in these two areas.

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

SVS does have concerns about the development of a Physician Compare web site by January 1, 2011, where the names and groups that successfully participate in PQRI will be posted. Consumers must be made aware that non-participation in this voluntary program does not indicate that a physician or group provides low quality care. SVS urges CMS to use extreme caution in publicizing this data, ensuring that it is not characterized as comparative quality data.

PQRI continues to be a program with low participation; there are many reasons that physicians might not participate 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. Participation in 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, we oppose penalties that are scheduled to begin in CY 2015 for physicians who do not successfully report PQRI measures. Until PQRI becomes more efficient and physician-friendly, we will work with Congress to delay these penalties.

Potentially Misvalued Services

SVS concurs with CMS' acknowledgment that the AMA RUC has made significant progress in addressing potentially misvalued services within the RBRVS. SVS has been an active participant in AMA RUC meetings for many years.

We agree that the RUC should review services that fall into the following categories as listed in the proposed rule: high volume/cost items, codes with low work RVUs commonly reported with multiple units, codes with high volume and low work RVUs and site-of-service anomalies.

Although appropriate for some services, we are concerned about consolidation of individual services into bundled codes for payment under the PFS. For example, a new coding structure was approved at the February 2010 CPT meeting and valued by the RUC in April 2010 for lower extremity endovascular arterial revascularization. These new CPT descriptions bundle the surgical procedure, radiology supervision and interpretation, and arterial catheterization for angioplasty, stent and atherectomy in the lower extremity. However, the non-facility reimbursement for multiple vessel therapy is still an issue. Previously, multiple vessel treatment relied upon both add-on coding and radiology coding, which are not subject to the 50 percent discount for multiple procedures. Traditionally, the discount helped negate overlap in pre- and post-operative care as well as certain portions of the surgical procedure (e.g.: scrub, dress and wait time).

In the facility setting, the practice expense component is quite small. Non-facility reimbursement for these endovascular procedures has a much larger practice expense to offset the cost of implantable devices such as intravascular stents, catheters, imaging equipment, etc. The coding structure no longer relies upon add-on and radiology coding. A 50 percent reduction of these codes is inappropriate and financially devastating to practices that specialize in peripheral intervention. At the April 2010 RUC meeting and in correspondence to the RUC in months thereafter, we proposed a 25 percent reduction as more appropriate. Leaving the 50 percent reduction will penalize the provider and encourage "staging" of multiple arterial lesions on separate days in some practices.

For the second time, SVS requests that CPT codes 34830, 34831 and 34832, concerning open repair of infrarenal abdominal aortic aneurysm or dissection, plus report of associated arterial trauma following unsuccessful endovascular repair, allow for assistant at surgery billing with either modifier -80 or -82. 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 a surgeon may have spent over four 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.

23-Hour Stays

Surgeons performing operations that require 23-hour stays provide substantial and necessary evaluation and management services to those patients throughout the day of surgery. This occurs in addition to the immediate post-op period. SVS is pleased that CMS included in the proposed rule that physician services related to the post-procedure services should be properly recognized and intra-service time of the inpatient hospital visit may be included in the valuation for the 23-hour code.

We continue to believe that for some 23-hour stay patients, discharge services provided during the day after surgery may require a full CPT 99238 rather than a .5 99238 routinely assigned to patients who go home on the day of a hospital outpatient procedure. An example would be a patient with multiple co-morbidities.

Also, we are concerned with CMS' position of overriding codes that the RUC has already classified as 23+ hour codes. Two such codes for vascular surgery are CPT 36821, AV access with direct vein to artery anastomosis and CPT 36825, creation of AV fistula by other than direct arteriovenous anastomosis. SVS presented compelling arguments through a full survey that patients receiving fistulas need to stay beyond 23 hours in the hospital and the RUC agreed. In addition, CMS' position on these codes is counter to its own Fistula First Initiative.

Application of Tissue-Cultured Skin Substitutes to Lower Extremities

CMS is proposing to eliminate six CPT codes that are already in existence and replace them with two G-codes for the application of Dermagraft and Apligraf along with eliminating the use of the -58 modifier. SVS is concerned that CMS is not being transparent and is setting a bad precedent by circumventing the RUC.

Future Updates to Prices of High-Cost Supplies

In the proposed rule, CMS discusses a refined process for regularly updating prices for high-cost supplies under the PFS and is soliciting comments on how CMS would improve the current process of using outside contractors. The process CMS is proposing would base high-cost supply price inputs on the publicly available prices listed on the General Services Administration (GSA) medical supply schedule and could occur every two years beginning as soon as CY 2013, although CMS notes that the agency would propose a refined process through rulemaking before revising the prices for any high-cost supply item.

SVS appreciates CMS moving forward with the recommendation that high-cost supplies be reviewed on a more frequent basis by updating these supplies every two years. However, SVS is concerned that CMS is proposing to base these updates on the inputs for these 62 high-cost supplies, including catheters used in vascular access procedures, on data from a pricing schedule that is administered by the Veteran's Administration (VA) under the authority of the GSA. We do not believe that the prices contained in this schedule consistently represent the prices available to non-VA providers and their practices. These schedules have historically been used by manufacturers and suppliers who only provide these high-cost supplies to the VA. SVS is greatly concerned by any proposal that would give the VA, instead of the AMA RUC, Practice Expense Advisory Committee or physician specialty societies, authority to determine the price of high-cost direct expense supply inputs in the Medicare PFS.

If CMS's true goal is accurate pricing of these inputs to reflect what physicians that provide care to Medicare beneficiaries in their community pay for these direct expense supply inputs, SVS recommends that CMS continue to use independent contractors in conjunction with physician specialty societies to develop prices for these items. CMS could again hold a series of refinement panels, similar to when the Clinical Practice Expert Panel databases were originally created to ensure updated pricing for each high cost input. SVS members participated in that process and would be happy to again participate in such a refinement process. Specialty societies could be mandated to provide pricing for the high-cost inputs represented in their codes as a condition of participating in these refinement panels.

Alternately, CMS could consider the creation of 62 new J-codes to be billed by physicians to reimburse for those supplies when provided to a patient as part of a procedure. Appropriate pricing for these J-codes could be determined by CMS on an annual basis.

Proposed CY 2011 Expansion of the Imaging Technical Component Multiple Procedure Payment Reduction (MPPR) Policy to Additional Combinations of Imaging Services

CMS is proposing to apply the MPPR to multiple imaging services furnished within the same family of codes or across families. Therefore, the MPPR would apply to CT and CTA, MRI and MRA, and ultrasound procedure services furnished to the same patient in the same session, regardless of the imaging modality and not limited to contiguous body areas.

SVS has concerns about this proposal because of its impact on lower cost, more efficient imaging modalities, such as ultrasound, and the disincentive this policy would create for use of these modalities, as these services would be the ones reduced by 50 percent if the physician also ordered an advanced imaging procedure for the patient during the same session. This new policy would create an incentive to exclusively use the advanced imaging procedure, if clinically it was not 100 percent certain that the ultrasound procedure would be able to isolate and diagnose the medical condition.

With limited efficiencies for imaging tests performed on the same day but with different modalities, such as a few minutes of clinical staff time to retrieve records and greet the patient, the proposed expansion of this policy across modalities and beyond contiguous body parts seems unwarranted and could cause inappropriate and expensive imaging as it creates disadvantages for the use of imaging modalities that have lower reimbursement.

ACA Section 3003: Improvements to the Physician Feedback Program

Under Section 3003 of the ACA, Congress directed CMS to refine and expand its current efforts to provide confidential feedback reports comparing cost and quality of care for all physicians and to use this data to create a value-based payment modifier by 2015.

CMS has also been directed by Congress to create a Medicare-specific transparent method of grouping episodes of care for Medicare beneficiaries with chronic conditions by January 1, 2012. Until the software exists, CMS is proposing to provide physicians with feedback reports, showing how they compare to their peers on total costs per Medicare beneficiary and total costs of treatment for five chronic care conditions: diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease and prostate cancer.

SVS would urge CMS to work very closely with the medical specialty societies in the creation, validation and testing phases for their method and software to be used for group episodes of care for chronic conditions. We would ask that CMS use a broad group of physicians, including surgeons, to validate and test the software. SVS would be happy to work with CMS on this project.

Risk adjustment is a very important aspect of this program and SVS again believes that CMS needs to convene various groups of medical specialties and work with them to define a risk-adjustment system for patients with chronic disease. For example, CMS and the specialty societies could outline the various characteristics that make a patient more difficult to treat and more resource intensive. Working together, a system of weighting these characteristics could be achieved by CMS that would be supported by the specialty societies.

Regarding attribution methods, SVS would encourage CMS to review methods that are based on which specialty is managing a patient's care long-term vs. which physician billed the majority of the cost. One surgical episode for a diabetic patient to help preserve a toe or foot could be the majority of the costs for a Medicare beneficiary during a given year, yet the surgeon only saw this patient for this one issue, with the primary care physician managing his/her overall care for diabetes for the entire year. Thus, the primary care physician should receive the attribution for this patient's care.

ACA Section 5501(b): Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas (HPSA)

For services furnished on or after January 1, 2011 and before January 1, 2016, CMS is proposing to provide a 10 percent incentive payment to general surgeons, identified by their enrollment in Medicare with a primary specialty code of 02 – general surgery, in addition to the amount they would be paid for their professional services under Part B, when they furnish a major surgical procedure in a location that was defined by the HHS Secretary as of December 31 of the prior year as a geographic HPSA.

SVS appreciates that CMS is implementing this provision of the ACA as it was intended, with new funding vs. making it budget neutral, which would have taken away reimbursements for other surgical specialties. Also, the SVS thanks CMS for allowing this new incentive payment to be paid in addition to other existing bonus payments for HPSA. As CMS may be aware, the specialty of vascular surgery has one of the most severe manpower shortages of any physician specialty, including primary care. According to the American Association of Medical Colleges' Physician Specialty Data Chart Book, there is only one vascular surgeon to provide care for every 121,600 Americans. In comparison, there is one general surgeon for every 11,300 Americans and one primary care physician for every 3,000 Americans.

ACA Section 6003: Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

Section 6003 of the ACA amends section 1877(b)(2) of the Act by creating a new disclosure requirement for in-office ancillary services exception to the prohibition on physician self-referral. Specifically, section 6003 provides that, with respect to referrals for magnetic resonance imaging (MRI), computed topography (CT), positron emission topography (PET) and any other DHS-

specified service under section 1877(h)(6)(D) that the Secretary determines appropriate, the referring physician must inform a patient in writing at the time of the referral that the patient may obtain the service from others besides the referring physician or someone in the physician's group practice and provide the patient with a list of 10 suppliers who furnish the service within 25 miles of where the patient resides.

SVS supports CMS in its proposal to not expand this disclosure requirement to other radiology or imaging services, such as ultrasound, that fall under section 1877(h)(6)(D) of the Act. Ultrasound is integrated into the clinical practice of vascular surgeons in caring for patients with vascular disease. Having the information from the ultrasound procedure in a timely manner, allowing for the information to be correlated immediately with the patient's other medical information, allows for a faster, more efficient diagnosis followed by treatment.

Unlike MRI, CT and PET, ultrasound procedures are rarely referred out to a free-standing imaging center, where patients could be given various screening options to consider. Ultrasound is typically performed in the physician's private practice office. It would be like conveying to patients that they need a second opinion if vascular surgeons were to talk to them about other places they should be aware of as options for receiving ultrasound procedures, given that the ultrasound test is part of an overall integrated patient care plan. CMS has made the right decision to not expand this requirement to include ultrasound procedures.

Section 132: Incentives for Electronic Prescribing (eRx) – The Electronic Prescribing Incentive Program

CMS is proposing that for 2011 eligible physicians need to report the e-prescribing measure for at least 25 visits during 2011 to qualify for the e-prescribing incentive payments equal to one percent of their total Medicare Part B allowed charges. While SVS appreciates that CMS' proposed reporting threshold of 25 takes into consideration that prescriptions are not generated with every Medicare Part B fee-for-service (FFS) patient encounter, that some prescriptions such as narcotics cannot be prescribed electronically and that not all Medicare Part B FFS encounters are represented by the electronic prescribing measure's denominator codes, we are concerned that this threshold for reporting may still be too high for vascular surgeons. For example, a busy vascular surgeon may see as many as 60 patients in a week in his/her office, yet not one of those visits may involve any type of prescription. Many patients seen by vascular surgeons are managed for their vascular conditions by internal medicine specialists and it is those physicians who titrate and prescribe their medications. In fact, the physician who is managing the patient would not be pleased if another physician changes the various levels and types of medications. Therefore, prior to 2012 and the implementation of the eRx penalty, SVS asks CMS to investigate its ability to propose a definition of a successful electronic prescriber that is specialty-specific, which would serve to broaden the exemption from penalties' category.

In addition, SVS is concerned with CMS' proposal that eligible physicians or group practices who fail to participate in the 2011 e-prescribing incentive program and do not quality for an exemption would be subject to financial penalties starting in 2012. Section 132(b)(5)(A)(i) of the Medicare Improvements for Patients and Providers Act of 2008 explicitly states on lines 2 and 3 that the penalty applies "with respect to covered professional services furnished by an eligible professional during 2012 or any subsequent year". SVS urges CMS to revise the penalty program so that financial penalties are based on lack of e-prescribing activity in 2012, not 2011, which is consistent with the law.

SVS appreciates the opportunity to submit these comments and looks forward to working with CMS to implement these recommendations. Please feel free to contact Pamela Phillips, Director of the SVS Washington Office at 202-787-1220 or pphillips@vascularsociety.org, if we can provide additional information or answer any questions.

Sincerely,

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