



September 14, 2007

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-1392-P - Medicare Program; Proposed Changes to the Hospital OPPS and CY 2008 Payment Rates and Proposed Changes to the Ambulatory Surgical Center (ASC) Payment Systems and CY 2008 Payment Rates

Dear Administrator Weems:

On behalf of the 2,300 members of the Society for Vascular Surgery (SVS), we offer the following comments on the Centers for Medicare & Medicaid Services' ("CMS") Medicare hospital outpatient prospective payment system ("OPPS") and ambulatory surgical center payment system ("ASC") proposed rule for calendar year 2008.

SVS supports CMS' interest in maintaining a hospital outpatient payment system that ensures the provision of necessary, high quality care that is provided in an efficient manner. However, we are concerned that subsets of the packaging proposals under the OPSS system will not create incentives for hospital efficiency or volume control, and may reduce access to care. Therefore, SVS would offer the following recommendations and comments for consideration prior to the implementation of CMS' proposals regarding the bypass list and increased packaging of services.

A. APC Relative Weights – By Pass List

SVS appreciates that CMS wants to use single procedure claims or through the creation of a by-pass list, "pseudo single" claims to set the medians on which APC relative payment rates are based. However, we are concerned that for minimally invasive vascular procedures that have been placed on the by-pass list, the data then available to CMS is causing the medians to be "artificially" capped, constrained, or reduced.

For example, CPT code 93880 – Duplex scan of extracranial arteries; complete bilateral study – in CY 2006 the median was \$156.20, in CY 2007 the median was \$155.19, and in proposed CY 2008 the median is \$160.96. The corresponding payment levels for these years are: \$152.01, \$151.25, and \$158.33. Yet in each of these years, the conversion factor has increased at least 3.5 percent. This cumulative increase is not realized for these codes. And for proposed CY 2008, with the packaging proposal being budget neutral causing the upward shift of payments for those remaining non-packaged codes, we would have expected an increase much greater than approximately \$7.00.

One assumption that could be made is that for codes that are on the by-pass list, CMS is using data to calculate median costs that is not typical for the service, but instead represents the cost of the procedure when it is performed for a patient who is not as severely ill as a patient who would require multiple procedures during the same day. Thus the claims being used to calculate the medians are the claims with the lowest costs, because these patients require the least amount of time and thus the lowest amount of hospital overhead, equipment allocation, staff, and follow-up.

SVS feels that it is important, especially given the fact that the hospital OPPS is now being used to set payment rates for these same procedures when performed in a physician's office, that CMS work with the SVS, its members, and their hospital partners to calculate the median costs for the typical patient, not the least expensive patient.

This "stagnation" in OPPS payments for minimally invasive vascular studies not only encourages hospitals to push for the ordering of more expensive and invasive tests, but it also is threatening access for Medicare patients in multiple sites of service.

SVS would like to work with CMS regarding the use of the by-pass list, its impact on the median costs for these minimally invasive vascular procedures on the list, and ways that CMS can use data that are more reflective of the real charges and costs for these procedures.

B. "Severe CCR-Based Payment Anomalies"

Realizing full well, and respecting for the most part, the CCR methodology used by CMS to set APC payments, SVS believes it is important to identify severe payment anomalies by making comparisons between analogous clinical services. This is most apparent and overt in the realm of noninvasive vascular diagnostic services. There is a direct one-to-one resource equivalence between noninvasive vascular lab studies in APC 0267 (CPT 93880, 93882, 93886, 93925, 93970, 93975, 93976, 93978) and transthoracic echocardiogram (APC 269, CPT 93307). The echocardiogram ultrasound scanner and the peripheral vascular duplex scanner are equivalent and cost the same amount. These two forms of ultrasound scanner are sold by the same vendors, come in the same frame, have equivalent transducer cost, and are shipped with very similar software. Oftentimes, smaller facilities use the VERY SAME machine to do echocardiograms and peripheral vascular duplex ultrasound. Therefore, the cost for equipment is equivalent. The labor type (vascular technologist vs. echocardiogram tech) is very similar, and in fact, the vascular technologist pay scale per minute in the CMS MPFS file is 2 cents per minute higher than the echo tech. Next, the time scheduled in typical facilities to perform transthoracic echocardiogram is equivalent to that for the noninvasive vascular studies listed above in APC 0267. Finally, the supplies required are essentially the same. Therefore, all resources (equipment, staff, supplies and study time) are nearly identical between services in APC 0267 and APC 0269, yet the payment difference between these two APCs is huge. Proposed payment for APC 0267 (noninvasive vascular services) is \$158.33, while proposed payment for APC 0269 is \$419.79.

This disparity between APC 0267 and APC 0269 is overt and not new. These two essentially equivalent services have had a 2.5 - 3x payment difference for several years. As the OPPS system expands to ASCs and unfortunately extends to the MPFS based on the DRA, SVS believes CMS has an obligation to examine disparities of this sort. Based on knowledge of the inputs, there is no doubt that APC 0267 is under-reimbursed by the CCR methodology. While

payment disparities may “come out in the wash” in large facilities, this is absolutely not the case in the ASC or MPFS setting.

In summary, SVS believes the proposed payment for APC 0267 is erroneously low and does not cover the resources required for the services in the APC. Since the OPPS CCR methodology now extends to ASCs and the MPFS, SVS strongly requests and recommends that CMS focus on the disparity between echocardiography and noninvasive vascular studies as it may offer insight to situations wherein the CCR methodology fails to track actual resource utilization. Failure to correct this payment anomaly will now extend the inequity across all of Medicare and may well result in extinction of very high quality noninvasive exams.

C. OPPS Packaged Services Proposal, Table 14

SVS is extremely concerned with the packaging proposal for the vascular radiological S&I services because other services have already been packaged into the S&Is. A second layer of packaging represents creation of a new and overtly inaccurate precedent. Typical peripheral vascular angiographic diagnostic and therapeutic services have been reported with a combination of selective catheter and device placement codes, and radiologic S&I codes, since 1992. However, the catheter placement codes have been bundled into the radiologic S&I codes for many years. All of the following catheter placement codes have “N” status in OPPS, yet all of these have absolute and real resource utilization (CPT 36005, 36010, 36011, 36012, 36013, 36014, 36015, 36100, 36120, 36140, 36145, 36160, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248).

To summarize, all the vascular catheterizations are bundled into the S&I codes and have no payment. Now, CMS proposes to package the S&I codes into each other with assignment of “Q” status to vascular APCs 0279, 0280 and 0668. This double packaging will result in payments that don’t even come close to covering resource utilization.

The two examples below (one for a diagnostic cerebrovascular arteriogram and the second for a diagnostic peripheral arteriogram) demonstrate how the 2008 proposed packaging methodology and the subsequent reduction in total payment will adversely impact vascular procedures that are routinely provided to Medicare beneficiaries. In each case, the equipment, supply, labor, and time inputs are very similar to those of diagnostic cardiac catheterization (APC 0080, CPT codes 93508-93533). The payment for cardiac catheterization APC 0080 is \$2,278 in 2007 and is proposed to be \$2,539 in 2008. Based on resource utilization, APC 0080 can be used a payment comparator for the following examples.

EXAMPLE 1: Full diagnostic 4-vessel cerebral arteriogram is routinely reported with the following 7 CPT codes:

1. CPT 36216 Place catheter in artery second order selective (right common carotid), 2007 & 2008 SI is N, payment = 0
2. CPT 36215 (Place catheter in artery, first order selective, left common carotid) 2007 & 2008 SI is N, payment = 0

3. CPT 36217 (Place catheter in artery, third order selective, right vertebral) 2007 & 2008 SI is N, payment = 0

4. CPT 36216-59 Place catheter in artery, 2nd order (left vertebral), 2007 & 2008 SI is N, payment = 0

5. CPT 75671 rad S&I cerebral vessels APC 0280 with 2007 payment = \$1280. Proposed 2008 SI is Q with payment = \$721.

6. CPT 75680 rad S&I bilateral cervical cerebral APC 0280 with 2007 payment = \$1280. Proposed 2008 SI is Q and payment after 1st Q service will be 0

7. CPT 75685 (times 2) rad S&I vertebral artery unilateral APC 0280 with 2007 payment = \$1280. Proposed 2008 SI is Q and payment after 1st Q service will be 0.

In summary, the 2007 payment for APC 0280 is \$1280, and the total payment for a full 4-vessel cerebral arteriogram is 4 x APC 0280 or 4 x \$1280 = \$5,120. The clinical inputs for this service include selective catheterization of 4 separate arteries from the aortic arch, and therefore the service represents more time and resource utilization than a left heart heart catheterization. Thus, in 2007, the payment of \$5,120 for a 4-vessel cerebral arteriogram is appropriate when compared to the \$2,278 payment for a 1 or 2 vessel cardiac catheterization. In 2008, however, based on the packaging proposal and the payment rules for status indicator Q, compounded by the mysterious 40% reduction in payment for APC 0280, the payment for the 4-vessel cerebral arteriogram will be only \$721, **representing an 83% payment reduction.** The payment of \$721 for 4-vessel cerebral arteriogram represents a huge rank order anomaly when compared to \$2,539 for cardiac catheterization. **Thus, the 83% payment reduction is totally unreasonable on a relative and an absolute basis.**

EXAMPLE 2: Diagnostic aortogram and full bilateral lower extremity arteriogram is reported with the following three CPT codes:

1. CPT 36246 2nd order selective catheterization (typically left external iliac artery from right femoral puncture): 2007 & 2008 SI indicator is N, 0 payment.

2. CPT 75625 radiological S&I aorta. APC is 0280 with 2007 status indicator S and payment of \$1280. Proposal for 2008 is change in status indicator for APC 0280 to Q, with payment reduced to \$721.

3. CPT 75716 radiological S&I for bilateral lower extremity arteriogram. APC is 0280 with 2007 status indicator S and payment of \$1280. Proposal for 2008 is change in SI to Q, with payment for this second Q service in this package of 0.

In summary, the 2007 payment for a full aortogram and bilateral lower extremity diagnostic arteriogram is \$2,560, appropriately comparable in 2007 to a one or two vessel cardiac catheterization (APC 0080) with a payment of \$2,278. This relationship is appropriate based on resource utilization. With the 2008 proposed packaging and associated status indicator change, the payment for aortogram and outflow arteriogram will be **reduced by 68%** to \$721. This is totally inadequate based on absolute resource utilization and totally inappropriate on a relative basis compared to cardiac catheterization APC 0080.

SVS strongly recommends and requests that the packaging proposal for vascular radiologic S&I codes, APC 0279, APC 0280, APC 0668 NOT be adopted in 2008 because 1) the packaging will result in payments vastly less than the cost of resources, 2) the packaging will result in payments vastly less than those of analogous services such as cardiac catheterization (APC 0080), and 3) it is methodologically circular and unreasonable to hyper-package services that already include other packaged services.

A final point in this regard is the payment for APC 0280. In 2007, payment is \$1280, and in 2008 the proposed payment is \$721, a remarkable 44% reduction. This is a very stable service, and it is unlikely that the median hospital charges for this service have fallen by 44%. Similarly, it is difficult to understand how the proposed packaging proposal should result in a reduction in payment of this magnitude. **SVS therefore requests that CMS examine the reason why proposed payment for APC 0280 would fall by 44% compared to 2007. This may provide insight to the impact of packaging, or it may represent a calculation error.**

SVS agrees with CMS that OPSS payments need to be adequate to ensure access to appropriate care. As CMS is aware, over the last several years with evolution of minimally invasive procedures, many vascular surgical services have successfully migrated from the inpatient to the outpatient setting, allowing the Medicare program to enjoy the savings that come with avoidance of inpatient hospitalization. Thus, we would argue that the growth in program expenditures for the OPSS should not be viewed in a vacuum but should take into account the positive impact this growth may be having on the overall health care system.

A major change starting with CPT 1992 was to delete many of the “complete procedure” codes and then the addition of new surgical codes in the 36000 series or cardiovascular section of the CPT Book. As reported in the Spring 1992 edition of the *CPT Assistant*, these 1992 coding changes were made to address the widely variant methods of reporting an interventional radiology procedure, in addition to whether it is one or two physicians performing the complete procedure, as CMS acknowledges in this 2008 proposed rule. Just referencing the parentheses in the CPT Book as a rationale for packaging radiological supervision and interpretation codes is not enough or appropriate regarding setting criteria for packaging. In fact, the catheter placement procedures are already bundled in the supervision and interpretation codes. CMS is now proposing essentially to double bundle these codes back into the “independent” surgery procedure codes. This is a circular logic algorithm that essentially negates nearly all payment for these resource intensive procedures.

We are concerned that CMS has not conducted an in-depth analysis where each independent code is crosswalked to each of the dependent codes in table 14 of the proposed rule to understand the average percentage of claims for independent codes with at least one dependent code. This is an extremely important analysis because the APC system is based on the concept of “medians” and with medians it is easy to dilute the medians used to set the relative weights for the APC when lower percentages of claims for independent claims have dependent or packaged codes on them. In this instance, which we believe is common in supervision and interpretation codes packaged with vascular surgery codes, the packaged code basically becomes so diluted that the hospital is essentially providing it for free. SVS believes that this type of scenario does not provide the right incentive for high quality care.

Finally, SVS believes that the scope of the packaging proposals and the literally hundreds of coding changes it would require presents huge operational challenges for our hospital partners to implement. These challenges must be addressed successfully by CMS. CMS has had negative experiences in past years when hospitals failed to continue to code and report packaged services on claims, such as with major medical devices. This makes it impossible in the future to accurately measure and understand the full array of services that are being provided to Medicare beneficiaries in the hospital outpatient setting, presenting real challenges for future updates to the APC system. Continued correct coding of any and all packaged services is a serious issue that must be addressed on an ongoing basis. Moreover, the use of the HCPCS code descriptors to determine whether or not separate payment is to be eliminated for particular imaging services raises other issues. For example, the Proposed Rule does not include clear information regarding the Agency's intentions on updating the HOPPS packaging policies to address newly added or deleted HCPCS codes.

For all these reasons, SVS requests that CMS postpone this packaging proposal for S&I services and instead work with medical societies and other stakeholders to review the proposal, conduct data analysis, hold town hall meetings and create with the community a set of specific packaging criteria/data rules that ensure Medicare beneficiaries will have access to the highest quality medical care.

D. OPSS Proposed Packaging Table 10 Image Processing

One service on the Table 10 list differs from the others. G0288 represents reconstruction of CT data for vascular surgical planning. It is extremely valuable in planning the best possible and safest endovascular abdominal aortic aneurysm repair. This is often an out-sourced service that is purchased by the hospital. If payment for G0288 is packaged, hospitals are unlikely to be willing to purchase the service, and Medicare beneficiaries will suffer. **SVS therefore requests that G0288 be removed from the list of packaged image processing in Table 10.**

E. Vascular services in the ASC

Many services provided by vascular surgeons are appropriately identified on the C-list, meaning that performance will only be covered as a hospital in-patient. Nevertheless, SVS believes there are continued difficulties with the exclusion of procedures involving major vessels. We plan to continue this dialogue with the Agency.

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SVS appreciates the opportunity to submit these comments and looks forward to working with CMS to implement these recommendations. Please feel free to contact Pam Phillips, Director of Health Policy and Government Relations at 703-573-7894 or PPhillips@vascularsociety.org, if we can provide further information.

Yours truly,
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