Alliance of Specialty Medicine

Sound Policy. Quality Care.

January 3, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Posted Electronically

Re: Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units

CMS-1524-FC
CMS-1436-F

Dear Acting Administrator Tavenner:

The Alliance of Specialty Medicine (Alliance) and its member organizations are writing to share our concerns with the final Medicare Physician Fee Schedule for CY 2012. The Alliance is a coalition of 11 national medical specialty societies representing more than 200,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

The Alliance will address the following issues in the final rule:

- Lack of transparency in the refinement panel process
- CMS policy on valuing surgical procedures with 23-hour stays
- Definition of “same session” for MPPR and
- Value-Based Modifier

Lack of transparency in the refinement panel process

Alliance members were pleased when CMS announced plans in the 2011 Medicare Physician Fee Schedule (MPFS) final rule to make the refinement process more transparent. Unfortunately, CMS did not fulfill its promise to improve the refinement process and has now indicated its intention to limit access to the process in the future. We appreciate that CMS published the results of the refinement panels convened in August of 2011. However, we are deeply disappointed that the agency chose to ignore the majority of the recommendations of the refinement panels. We are particularly concerned about CMS' refusal to accept the refinement recommendations for codes for which CMS says it has an established policy, such as the codes that were identified by the "site of service" screen. All of the

specialties represented at the Alliance agree that the CMS policy undervalues the physician work in these surgical codes that are now 23+ hour observation stays. CMS has not provided any data to support this policy. If refinement panel recommendations are uniformly overturned on the basis of pre-existing CMS policy, there is no utility in the panels for CMS or physicians. We urge CMS to revisit this position and to carefully assess refinement panel recommendations for all codes for which specialty societies request re-review. Refinement panel recommendations should not be ignored due to CMS "policy". CMS has not provided adequate justification for these actions and we urge CMS to reconsider and accept the values recommended by the objective refinement panels.

In addition, CMS states in the final rule that it will require new data, not presented at the RUC, to consider codes for the refinement process in the future. While we agree that physician societies should be permitted to submit additional data when available, we do not agree with limiting the opportunity for refinement only to those specialties that have information not presented at the RUC. In many instances, there is no additional information to provide to a refinement panel because all available data has been presented to the RUC. The refinement process provides an opportunity for specialty societies to present all available data on procedures under consideration to a panel of objective experts, as a form of appeal. For twenty years, refinement panels have been an important mechanism for review of CMS decisions. We applaud the publication of the results of the refinement panels. We feel CMS should provide rationales supported by data to explain their decisions to reject refinement panel results. Finally, we completely disagree with the agency's proposal to limit access to the refinement process to only those specialties presenting information not shared at the RUC.

CMS policy on valuing surgical procedures with 23-hour observation stays

The Alliance supports the AMA RUC policy of recognizing the time the physician spends in the hospital taking care of the surgical patient. The content of the care does not vary with the outpatient or inpatient designation by the hospital. The same evaluation and management services are provided to these patients regardless of "observation" status. We do not agree that there is a decrease in the time and/or intensity of services for these patients. CMS disagreed with the RUC recommended values for many surgical codes and rejected refinement panel recommendations for higher values because CMS believes "that it is reasonable to expect that there have been changes in medical practice for these services, and that such changes would represent a decrease in physician time or intensity or both. However, the AMA RUC-recommendation and refinement panel results do not adequately reflect a decrease in physician work." The same reductions in work values for Evaluation and Management codes for non-surgical follow-up of patients on observation status have not been implemented. The result of these actions is differential payments for follow-up of patients on observation status depending on which types of physician provide the follow-up. CMS provides no logical or data-driven basis to support this differentiation. CMS should value care provided to patients on observation status uniformly regardless of the type of physician providing the care.

Definition of "Same Session"

Although the Alliance maintains its objections to extension of the Multiple Procedure Payment Reduction (MPPR) to the professional component of certain imaging procedures, we welcome CMS' decision to finalize a lower reduction in payment (25 percent instead of 50 percent) which more closely approximates physician time spent on imaging interpretations. We note that CMS has stated in the final rule that only three percent of imaging involves use of two or more different modalities on the same day in the same session. CMS also recognizes that "it may not always be a simple matter to determine whether a service was furnished in the 'same' session, particularly in the case of the PC.

The physician will need to exercise judgment to determine when it is appropriate to use the -59 modifier indicating separate sessions. We do not expect use of the modifier to be a frequent occurrence." The final rule suggests that moving a patient to a separate floor for a second modality would generate a second session for purposes of the technical component, but interpretation of the images in the same timeframe would be considered the same session. Use of two or more modalities often requires moving a patient to a separate room if not a second floor. We request that CMS define "same session" or better, drop the application of the MPPR to separate modalities. If use of two or more modalities comprises such a low percentage of imaging volume, the potential savings derived from this policy will not justify the confusion it will create.

Value-based payment modifier

At the December 5, 2011 briefing on the quality provisions under the Physician Fee Schedule 2012 Final Rule, CMS staff indicated that they are working on an attribution method whereby care from physicians is differentiated into "directed care," "influenced care," and "contributed care." However, the specifics of this attribution methodology have yet to be fully defined. Since the attribution methodology is one of the fundamental foundations of the value-based program, we urge CMS to actively seek input from stakeholders by holding multiple public meetings prior to the 2013 rulemaking cycle. Additionally, it is imperative that during these public meetings CMS provide examples showing how the attribution methodology works so that stakeholders can clearly understand the calculations. Before implementing the use of the attribution methodology, CMS should test the methodology to ensure that it can account for most of the total Part A and B costs and covers most individual physicians.

Thank you for your consideration of the concerns of specialty physicians. If you have questions on our comments, please contact: Inger Saphire-Bernstein (isaphirebernstein@auanet.org), Cathy Hill (chill@neurosurgery.org, or Lu Lu Lee(llee@auanet.org).

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Gastroenterological Association
American Society of Cataract & Refractive Surgery
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
North American Spine Society
Society for Cardiovascular Angiography and Interventions