Submitter : Dr. Mark Kowalski **Date:** 11/03/2006

Organization : Orthopaedic and Sports Specialists, P.C.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

November 3, 2006

Leslie V. Norwalk, Esq.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: 2007 OPPS Proposed Rule (CMS-1506-P) Comments on Proposed Revised Ambulatory Surgical Center Payment System for Implementation January 1, 2008 (Section XVIII)

Dear Administrator Norwalk:

I am writing to you concerning the above Rulemaking published on June 12, 2006, regarding updates to rate-setting methodology, payment rates, payment policies, and the list of covered surgical procedures for ambulatory surgical centers. I am the facility <administrator (or insert physician)> at the<Name of ASC >Ambulatory Surgical Center, a <multi-specialty, endo, opth, etc> facility located in <city, state>.

The goal for all of us--providers, physicians, and payors--is to create a health care system that delivers excellent clinical outcomes in a cost efficient environment.

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Aet of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. Given the antiquated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. The following comments focus on three prineiples:

1) Maximizing parity between the ASC and HOPD payment systems to prevent differences between the payment systems

2) Ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC

3) Establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

1. ASC Payable Procedures (Section XVIII.B.1)
We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inelusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.
2. ASC Unlisted Procedures (Section XVIII.B.2)
At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.
3. ASC Office-Based Procedures (Section XVIII.B.3)
We support CMS s proposal to extend the new ASC payment system to cover proeedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.
4. ASC Ratesetting (Section XVIII.C.2); ASC Packaging (Section XVIII.C.3); ASC Payment for Office-Based Procedures (Section XVIII.C.5); ASC Multiple Procedure Discounting (Section XVIII.C.6); ASC Wage Index (Section XVIII.C.7); ASC Inflation (Section XVIII.C.8)
We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage ind

Submitter : **Dr. Ramsin Benyamin** **Date: 11/03/2006**

Organization : **Millennium Pain Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a practicing interventional pain physician, I am disappointed at CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals, ASCs, and beneficiaries access will be harmed. While this may be good for some specialties, interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% in 2009 and after). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts. Using this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Based on this rationale, I suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I hope this letter will assist in coming with appropriate conclusions that will help the elderly in the United States.

Sincerely,
Ramsin Benyamin

Submitter : Dr. James Klein **Date:** 11/03/2006

Organization : Metropolitan Eye Center & Outpatient Surg. Facilit

Category : Physician

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

November 3, 2006

Leslie V. Norwalk, Esq.

Dear Ms. Norwalk:

I am drafting this letter as brief comments to CMS regarding the proposed rulemaking for ASC payment reform.

I am the owner of Metropolitan Eye Center. This is a full-service eye center, including a completely Medicare and AAAHC certified ambulatory surgery center. We were the first ambulatory center to be approved in Michigan and have been in operation since 1984. We serve approximately 2,000 Medicare patients a year doing primarily cataract and glaucoma surgery. Our patients are almost uniformly satisfied with the service provided and continue to comment how much more efficient and patient centered our Center is when compared with hospital outpatient departments. We have full anesthesia coverage during our procedures and perform at, or above, the level of hospital outpatient surgery departments in our area.

I spite of our numbers, we have continued to have increased capacity which could be used to perform other related ophthalmic procedures if the ASC procedures list were expanded. In my opinion, the ASC procedures list at this time remains far too restrictive and should be expanded to include all outpatient surgery procedures performed in hospital outpatient departments.

As you know, our surgery center has not received any increases in reimbursement and has not been promised any in the future. This is in spite of the fact capital improvements, to remain technologically up-to-date, require approximately $75,000 to $100,000 capital spending each year. This is in addition to increasing competition for nursing staff, which requires increasing salaries on a yearly basis to compete with hospital outpatient departments when compared with ASCs. Since our capital expenditures are equivalent to hospital outpatient departments, and we must compete for the same medical personnel, it is unrealistic to expect that we can continue to provide services at only 62% of procedural rates paid.

I am willing to share with Medicare some of the efficiencies of my practice so that an ASC rate at approximately 75-80% would allow me to provide efficient and superior service while saving Medicare considerable amounts of money. This uniform percentage of payment should be the same for all services whatever specialty.

I feel it would be certainly fair, and appropriate, if annual payment updates of ASC rates were included in this proposal so as to make an even paying field with hospital outpatient departments. The new payment system should provide hospital market updates to both ASCs and HOPDs since both provide the same services and incur the same costs in delivering high quality surgical care.

Without these increases, adjustments and reductions in access to service by Medicare patients will certainly have to be cut. This will also result in reductions to personnel and capital expenditure which in the long run will have an effect to reduce general economic activity and retard the continued progression of highly sophisticated technological services which to date has been provided to our Medicare patients with no increase in reimbursement.

Please carefully consider my comments as you develop an ASC payment system which will be fair and equitable for all.

Sincerely,

James W. Klein, M.D.
Medical Director

Metropolitan Eye Center
& Outpatient Surgical Facility
21711 Greater Mack Ave.
St. Clair Shores, MI 48080
586/774-0393

Submitter : Dr. JOSEPH LEONI **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-837-Attach-1.DOC

#857

BERKS UROLOGIC SURGERY CENTER
AAAHC Accredited Facility
1320 BROADCASTING ROAD STE 210
WYOMISSING PA 19610
(610) 685-1044

November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P2
PO Box 8011
Baltimore MD 21244-8013

Dear Sir/Madam:

As a physician/owner of a single specialty, urologic ambulatory surgery center (ASC), I would like to provide feedback regarding the proposed changes to how ASCs' will be reimbursed starting in 2008. As an introduction, in 2005, our ASC had over 5,000 patient visits and at least 46% of those patients are Medicare age.

Significant Impact on *Our* Surgery Center
After reviewing the impact the proposed changes would have on our ASC we discovered that our revenue (from just Medicare patients) would fall by $56,672 in 2008 with the transition payment and by $87,971 without the transition payment (assuming volume per procedures remains the same and is based on procedures currently being done in the ASC). That is a decline of almost 3% in revenue received for Medicare patients. This would create a serious financial hardship on our independently owned ASC. While our revenue is being cut our expenses are increasing on items like wages, benefits, malpractice insurance and supply costs.

"Office based" Procedure CAPS
While I am appreciative of the proposed decision to allow a significant number of procedures to be added to the "approved" list of CPT codes with a facility fee, I have serious concerns about the CAP levels. First, the CAPS should not be included in the final rules because their main purposes are for fiscal constraint and to prevent migration of procedures from the office to the ASC setting. The CAP disregards and discounts the additional complexity and costs associated with performing procedures in the regulated ASC environment which are needed to safely care for a significant number of Medicare beneficiaries. CMS should reimburse ASCs at an adequate level so these procedures can be done properly in the ASC setting.

Also, there are no CAPS applied to the hospital outpatient prospective payment system (OPPS) possibly because CMS recognizes that the cost of a procedure can vary based on the medical conditions of the beneficiary and the resources available and the required site of service. In fact, in a recently released MedPAC study, the differences between the costs and quality outcomes of selected procedures, when the cases were performed in ASCs and HOPDs, were insignificant. The CAP should also be considered inappropriate for the ASC setting and should be omitted from the final regulations.

However, if the CAP system has to be implemented, I would urge you to EXEMPT all of the procedures on the 2007 Medicare approved list from the CAP and they should be exempt from the "office based" classification forever. If this is not done, it has been estimated that the reimbursement for our high volume procedures (e.g., cystoscopy, prostate biopsy, and Urodynamics) would be reduced by OVER 90 PERCENT! That would force the closure of our ASC and would lead to the elimination of at least eleven jobs. It would also lead to the closure of other independent ASCs. By "forcing" patients to have their procedures in unregulated physician offices or requiring them to travel to hospitals could compromise patient safety and access to healthcare services for a significant portion of the Medicare population. This would be a significant step backwards for the healthcare delivery system in America.

62% Conversion Factor

CMS is mandated to revise the ASC payment system in a "revenue neutral" manner and that is how they arrived at the 62% conversion factor. There is also an assumption that the cost of providing such services in the ASC is less costly than in a HOPD. While this last assumption may be true for some procedures it is not the case for procedures requiring high cost prosthetics. For these procedures the cost of the implant drives the cost of the procedure and the ASCs and HOPDs should be reimbursed in the same manner and the same amount for implants. In our ASC the use of slings (CPT 57288) for incontinence is a good example of a procedure requiring the use of a high priced implant that needs to be reimbursed adequately. For 57288, the cost for the sling material *alone* can be over $900 per procedure.

By setting the conversion factor at 62%, ASCs would stop performing procedures when they would be losing money. Physicians performing the cases in the ASCs may not have the appropriate office space, equipment, supplies, anesthesia requirements or staff to safely perform those procedures in their office and would have to shift patients back to the hospital. This would increase the amount paid by Medicare beneficiaries and the federal government. It would again compromise patient access to quality care.

The proposed rate setting would be based on a complicated formula to link ASC payments to HOPD payments but does not do so in a uniform manner. This will impede Medicare patients' ability to understand the real cost in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

High Cost Leased Technology

We were pleased to see the addition of CPT code 50590 Lithotripsy to the list of approved codes in 2008. We are concerned, however, by the fact that all of our facility fee would be used to lease the equipment from our vendor. The CMS proposed fee is $1,750, while under our current (fair market value) lease terms we have to pay $2,200 to our vendor which would make it impossible to offer this service to Medicare patients. Once again, this would make Medicare pay out a higher rate of reimbursement to the hospital (since it cannot be done in the ASC or our office) and limit patient access to care in a convenient setting.

CMS-1506-P2 Comments

Other Payment Policy Concerns

Payment Bundles
Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

Different Measures of Inflation
CMS updates the OPPS conversion factor for annual changes in inflation based on the hospital market basket while it proposes to update ASC payments using a version of the CPI. The hospital market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by CMS to update payments to hospitals providing the same outpatient services.

New Technologies
While CMS has demonstrated support of procedures provided in the HOPD by including additional payment for high-cost outliers and payments for new technologies, no such policies have been proposed for ASCs. ASCs should be eligible to receive new technology pass through payments.

Treatment of Unlisted Codes
Occasionally surgeons perform services for which CPT does not provide a specific code and therefore uses an unlisted procedure code to identify the service. Since HOPDs receive payments for such unlisted codes under the OPPS; ASCs should also be eligible for payment of selected unlisted codes.

Budget Neutrality
The Lewin Group estimates that the inflation updates applied to the HOPD rate since passage of the Medicare Modernization Act accounts for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. When you combine this with the narrow interpretation of budget neutrality in the proposed rule, you are left with an unacceptably low conversion factor for ASC payments.

CMS should adopt an expansive, realistic interpretation of budget neutrality. CMS should examine how migration of services could impact all three settings (office, ASC and HOPDs) and not just assume it will all be between procedures going from the office setting to the ASC setting.

If you require any additional information about the points I have mentioned or how the proposed rules will impact my ASC or if you would like a tour of our ASC please feel free to contact me at (610) 372-8995.

Thank you for your careful consideration of my comments.

Respectfully,

Joseph V. Leoni, MD
Medical Director
Berks Urologic Surgery Center

Submitter : **Date: 11/03/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

As the physician owner of an Ophthalmology ASC, I would like to join my colleagues in voicing my opposition to the proposed changes in the ASC payment system. CMS needs to more broadly interpret the budget neutrality provision enacted by Congress. 62% is simply not adequate. 70-75% is what is needed to assure Medicare beneficiaries access to ASCs.
Additionally, the ASC list reform proposed by CMS is too limited. Only those procedures that are on the inpatient only list should be excluded.
I believe, as do the majority of my colleagues, that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payments systems for ASCs and hospital outpatient departments, and that this should be done to the greatest extent permitted by law.

Submitter : Dr. JAY MILLER **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-839-Attach-1.DOC

#839

BERKS UROLOGIC SURGERY CENTER
AAAHC Accredited Facility
1320 BROADCASTING ROAD STE 210
WYOMISSING PA 19610
(610) 685-1044

November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P2
PO Box 8011
Baltimore MD 21244-8013

Dear Sir/Madam:

As a physician/owner of a single specialty, urologic ambulatory surgery center (ASC), I would like to provide feedback regarding the proposed changes to how ASCs' will be reimbursed starting in 2008. As an introduction, in 2005, our ASC had over 5,000 patient visits and at least 46% of those patients are Medicare age.

Significant Impact on *Our* Surgery Center
After reviewing the impact the proposed changes would have on our ASC we discovered that our revenue (from just Medicare patients) would fall by $56,672 in 2008 with the transition payment and by $87,971 without the transition payment (assuming volume per procedures remains the same and is based on procedures currently being done in the ASC). That is a decline of almost 3% in revenue received for Medicare patients. This would create a serious financial hardship on our independently owned ASC. While our revenue is being cut our expenses are increasing on items like wages, benefits, malpractice insurance and supply costs.

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Also, there are no CAPS applied to the hospital outpatient prospective payment system (OPPS) possibly because CMS recognizes that the cost of a procedure can vary based on the medical conditions of the beneficiary and the resources available and the required site of service. In fact, in a recently released MedPAC study, the differences between the costs and quality outcomes of selected procedures, when the cases were performed in ASCs and HOPDs, were insignificant. The CAP should also be considered inappropriate for the ASC setting and should be omitted from the final regulations.

However, if the CAP system has to be implemented, I would urge you to EXEMPT all of the procedures on the 2007 Medicare approved list from the CAP and they should be exempt from the "office based" classification forever. If this is not done, it has been estimated that the reimbursement for our high volume procedures (e.g., cystoscopy, prostate biopsy, and Urodynamics) would be reduced by OVER 90 PERCENT! That would force the closure of our ASC and would lead to the elimination of at least eleven jobs. It would also lead to the closure of other independent ASCs. By "forcing" patients to have their procedures in unregulated physician offices or requiring them to travel to hospitals could compromise patient safety and access to healthcare services for a significant portion of the Medicare population. This would be a significant step backwards for the healthcare delivery system in America.

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By setting the conversion factor at 62%, ASCs would stop performing procedures when they would be losing money. Physicians performing the cases in the ASCs may not have the appropriate office space, equipment, supplies, anesthesia requirements or staff to safely perform those procedures in their office and would have to shift patients back to the hospital. This would increase the amount paid by Medicare beneficiaries and the federal government. It would again compromise patient access to quality care.

The proposed rate setting would be based on a complicated formula to link ASC payments to HOPD payments but does not do so in a uniform manner. This will impede Medicare patients' ability to understand the real cost in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

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CMS-1506-P2 Comments

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Thank you for your careful consideration of my comments.

Respectfully,

Jay B. Miller, MD
Surgeon
Berks Urologic Surgery Center

Submitter : Dr. JOHN HENRY **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-840-Attach-1.DOC

#640

BERKS UROLOGIC SURGERY CENTER
AAAHC Accredited Facility
1320 BROADCASTING ROAD STE 210
WYOMISSING PA 19610
(610) 685-1044

November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P2
PO Box 8011
Baltimore MD 21244-8013

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CMS-1506-P2 Comments

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Thank you for your careful consideration of my comments.

Respectfully,

John M. Henry, MD
Surgeon
Berks Urologic Surgery Center

Submitter : Dr. Esmail Elwazir **Date:** 11/03/2006

Organization : TDDC

Category : Physician

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

I would like to voice my strong opposition to the implementaion of this proposal for the following reasons:
1. By reducing paymcnts to ASC units the proposal will restrict MDCR paticnt's access to the most convenicnt, efficient, and cost effective vehicle for delivering endoscopic procedures, including screening colonoscopies. The draconian cut in reimbursement will make care for MDCR patient's in this setting less economically feasible for ASC's. As a result these patients will be cared for in HOPD departments which generally are a higher cost lower service venue.
2. By increasing the differential between HOPD and ASC's a payment structure encouraging use of higher cost, lower efficiency delivery systems is created. This unfairly subsidizes hospitals.
3. The decrease in ASC reimburement places an unreasonable burden on ASC's which are essentially small businesses and may lead to the stunting of economic activity in that sector with possibly the loss of thousands of jobs.
Sincerely,
Esmail Elwazir

Submitter : Dr. STEPHEN SIHELNIK **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-842-Attach-1.DOC

#842

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(610) 685-1044

November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P2
PO Box 8011
Baltimore MD 21244-8013

Dear Sir/Madam:

As a physician/owner of a single specialty, urologic ambulatory surgery center (ASC), I would like to provide feedback regarding the proposed changes to how ASCs' will be reimbursed starting in 2008. As an introduction, in 2005, our ASC had over 5,000 patient visits and at least 46% of those patients are Medicare age.

Significant Impact on *Our* Surgery Center
After reviewing the impact the proposed changes would have on our ASC we discovered that our revenue (from just Medicare patients) would fall by $56,672 in 2008 with the transition payment and by $87,971 without the transition payment (assuming volume per procedures remains the same and is based on procedures currently being done in the ASC). That is a decline of almost 3% in revenue received for Medicare patients. This would create a serious financial hardship on our independently owned ASC. While our revenue is being cut our expenses are increasing on items like wages, benefits, malpractice insurance and supply costs.

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CMS-1506-P2 Comments

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The proposed rate setting would be based on a complicated formula to link ASC payments to HOPD payments but does not do so in a uniform manner. This will impede Medicare patients' ability to understand the real cost in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

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CMS-1506-P2 Comments

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If you require any additional information about the points I have mentioned or how the proposed rules will impact my ASC or if you would like a tour of our ASC please feel free to contact me at (610) 372-8995.

Thank you for your careful consideration of my comments.

Respectfully,

Stephen A. Sihelnik, MD
Surgeon
Berks Urologic Surgery Center

Submitter : Dr. ALAN FLEISCHER **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-843-Attach-1.DOC

#843

BERKS UROLOGIC SURGERY CENTER
AAAHC Accredited Facility
1320 BROADCASTING ROAD STE 210
WYOMISSING PA 19610
(610) 685-1044

November 3, 2006

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Department of Health and Human Services
Attn: CMS-1506-P2
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CMS-1506-P2 Comments

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Respectfully,

Alan N. Fleischer, MD
Surgeon
Berks Urologic Surgery Center

Submitter : Dr. CONSTANTINE HARRIS **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-844-Attach-1.DOC

#844

BERKS UROLOGIC SURGERY CENTER
AAAHC Accredited Facility
1320 BROADCASTING ROAD STE 210
WYOMISSING PA 19610
(610) 685-1044

November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P2
PO Box 8011
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CMS-1506-P2 Comments

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CMS-1506-P2 Comments

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Respectfully,

Constantine F. Harris, MD
Surgeon
Berks Urologic Surgery Center

Submitter : **Pamela Isabel** **Date: 11/03/2006**

Organization : **Woodholme Gastroenterology Associates**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

I am writing to request further investigation into the proposed modifications as they relate to gastroenterology procedures performed in ASC's. It is my understanding that the rate of payment will be significantly reduced below hospital rates. I do not understand how the GI facilities will be able to compete when they draw from the same pool of nurses, utilize the same equipment, and utilize the same supplies. Why should hospitals be paid more. ASC's provide great access to the public and are a cost effective way of providing colonoscopies. I am requesting that the proposed payment plan be re-evaluated so that gastroenterology is not punished. Thank you.

Submitter : Mr. CHARLES I BUSACK **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-846-Attach-1.DOC

#846

BERKS UROLOGIC SURGERY CENTER
AAAHC Accredited Facility
1320 BROADCASTING ROAD STE 210
WYOMISSING PA 19610
(610) 685-1044

November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P2
PO Box 8011
Baltimore MD 21244-8013

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Administrator
Berks Urologic Surgery Center

Submitter : Ms. CAROLE SHIRK **Date:** 11/03/2006

Organization : BERKS UROLOGIC SURGERY CENTER

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1506-P2-847-Attach-1.DOC

847

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November 3, 2006

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Attn: CMS-1506-P2
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CMS-1506-P2 Comments

However, if the CAP system has to be implemented, I would urge you to EXEMPT all of the procedures on the 2007 Medicare approved list from the CAP and they should be exempt from the "office based" classification forever. If this is not done, it has been estimated that the reimbursement for our high volume procedures (e.g., cystoscopy, prostate biopsy, and Urodynamics) would be reduced by OVER 90 PERCENT! That would force the closure of our ASC and would lead to the elimination of at least eleven jobs. It would also lead to the closure of other independent ASCs. By "forcing" patients to have their procedures in unregulated physician offices or requiring them to travel to hospitals could compromise patient safety and access to healthcare services for a significant portion of the Medicare population. This would be a significant step backwards for the healthcare delivery system in America.

62% Conversion Factor

CMS is mandated to revise the ASC payment system in a "revenue neutral" manner and that is how they arrived at the 62% conversion factor. There is also an assumption that the cost of providing such services in the ASC is less costly than in a HOPD. While this last assumption may be true for some procedures it is not the case for procedures requiring high cost prosthetics. For these procedures the cost of the implant drives the cost of the procedure and the ASCs and HOPDs should be reimbursed in the same manner and the same amount for implants. In our ASC the use of slings (CPT 57288) for incontinence is a good example of a procedure requiring the use of a high priced implant that needs to be reimbursed adequately. For 57288, the cost for the sling material *alone* can be over $900 per procedure.

By setting the conversion factor at 62%, ASCs would stop performing procedures when they would be losing money. Physicians performing the cases in the ASCs may not have the appropriate office space, equipment, supplies, anesthesia requirements or staff to safely perform those procedures in their office and would have to shift patients back to the hospital. This would increase the amount paid by Medicare beneficiaries and the federal government. It would again compromise patient access to quality care.

The proposed rate setting would be based on a complicated formula to link ASC payments to HOPD payments but does not do so in a uniform manner. This will impede Medicare patients' ability to understand the real cost in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

High Cost Leased Technology

We were pleased to see the addition of CPT code 50590 Lithotripsy to the list of approved codes in 2008. We are concerned, however, by the fact that all of our facility fee would be used to lease the equipment from our vendor. The CMS proposed fee is $1,750, while under our current (fair market value) lease terms we have to pay $2,200 to our vendor which would make it impossible to offer this service to Medicare patients. Once again, this would make Medicare pay out a higher rate of reimbursement to the hospital (since it cannot be done in the ASC or our office) and limit patient access to care in a convenient setting.

CMS-1506-P2 Comments

Other Payment Policy Concerns

Payment Bundles
Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

Different Measures of Inflation
CMS updates the OPPS conversion factor for annual changes in inflation based on the hospital market basket while it proposes to update ASC payments using a version of the CPI. The hospital market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by CMS to update payments to hospitals providing the same outpatient services.

New Technologies
While CMS has demonstrated support of procedures provided in the HOPD by including additional payment for high-cost outliers and payments for new technologies, no such policies have been proposed for ASCs. ASCs should be eligible to receive new technology pass through payments.

Treatment of Unlisted Codes
Occasionally surgeons perform services for which CPT does not provide a specific code and therefore uses an unlisted procedure code to identify the service. Since HOPDs receive payments for such unlisted codes under the OPPS; ASCs should also be eligible for payment of selected unlisted codes.

Budget Neutrality
The Lewin Group estimates that the inflation updates applied to the HOPD rate since passage of the Medicare Modernization Act accounts for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. When you combine this with the narrow interpretation of budget neutrality in the proposed rule, you are left with an unacceptably low conversion factor for ASC payments.

CMS should adopt an expansive, realistic interpretation of budget neutrality. CMS should examine how migration of services could impact all three settings (office, ASC and HOPDs) and not just assume it will all be between procedures going from the office setting to the ASC setting.

If you require any additional information about the points I have mentioned or how the proposed rules will impact my ASC or if you would like a tour of our ASC please feel free to contact me at (610) 372-8995.

Thank you for your careful consideration of my comments.

Respectfully,

Carole Shirk, RN
Clinical Nurse Director
Berks Urologic Surgery Center

Submitter : Dr. David Kloth **Date:** 11/03/2006

Organization : Connecticut Pain Care

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see Attachment

CMS-1506-P2-848-Attach-1.DOC

848

David S. Kloth, M.D.
Medical Director

David C. Levi, M.D.
Robert J. Boolbol, M.D.
Pardeep Sood, M.D.

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Hubert H. Humphrey Building. Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Via email: http://www.cms.hhs.gov/erulemaking

Re: CMS-1506-P2 - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

As a practicing interventional pain physician, I am disappointed at CMS's proposed rule for ASC payments. This rule will create significant inequities between hospitals, ASCs, and beneficiaries' access will be harmed. This will create a significant negative impact for interventional pain management (approximately 20% in 2008 and approximately 30% in 2009 and after). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not feasible for single specialty centers. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone follows Medicare's lead. If the proposed rule for ASC payments for calendar years 2008 and 2009 is accepted, Medicate beneficiaries' access to care will be severely harmed. Procedures may shift to the hospital outpatient setting, leading to increased cost to the Medicare program.

Interventional Pain Management procedures are already reimbursed at the lowest levels of all ASC surgical procedures. I, therefore, suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at no less than the present rate and not allow cuts that would reduce the reimbursement below these rates. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I CMS will reach appropriate conclusions and help the Medicare population of the United States.

Sincerely,

David Kloth, M.D.

109 Newtown Road · Danbury, CT 06810 · 203-792-PAIN (7246)
5520 Park Avenue, #303 · Trumbull, CT 06611 · 203-373-7330
1389 West Main Street, #123, Tower 2 · Waterbury, CT 06708 · 203-596-7302
81 Gillett Street · Hartford, CT 06105 · 860-247-0033
148 East Avenue, #3D · Norwalk, CT 06851 · 800-361-4383
131 Kent Road, Bldg A #201 · New Milford, CT 06776 ·860-355-0338
1-800-361-4383 Fax: 203-792-9636

Submitter : Mrs. Ellen Bencken **Date:** 11/03/2006

Organization : Orthopedic Surgery Center of Idaho

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached

CMS-1506-P2-849-Attach-1.DOC

849

ORTHOPEDIC
SURGERY
CENTER OF
IDAHO

1425 W River
Boise, ID 83702-6861

208-342-1932
208-336-1954 (fax)

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Proposed Medicare Payment Changes

My name is Ellen Bencken, RN, BSN, CNOR and I am the Director of Nursing of the Orthopedic Surgery Center of Idaho in Boise, Idaho. Our ambulatory surgery center (ASC) offers orthopedic surgical services and has been providing high quality, patient centered, and cost effective interventional procedures and surgery since February 2002. Our 28 employees and 20 surgeons care for approximately 3200 patients a year (this includes over 340 Medicare beneficiaries) at our surgery center. I am taking this opportunity to offer our concerns regarding the payment rates for ASCs proposed by the Centers for Medicare and Medicaid Services (CMS).

In 2008, CMS essentially proposes to pay ASCs 38 percent less than what they pay a hospital for the exact same surgical procedure. This untenable price differential, which will widen further over time, is unrelated to the costs that ASCs incur in delivering services. It is driven entirely by the agency's narrow interpretation of budget neutrality requirements and will jeopardize the ability of many ASCs to continue to provide high quality surgical care to Medicare beneficiaries. (The ASC industry recommends that ASCs be paid at 75% of hospital rates.)

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient department services (HOPD) were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under Outpatient Payment System (OPPS); ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require

ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary.

Medicare payment rates for ASC services have remained stagnant for nearly a decade. The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

We strongly feel there is a better way to design the new ASC payment system, and would like the Centers for Medicare and Medicaid (CMS) to work with the ASC industry to find a more equitable system. Thank you for allowing us the opportunity to share our concerns.

Sincerely,

Ellen Bencken, RN, BSN, CNOR

Submitter : Dr. Robert Hollabaugh **Date:** 11/03/2006

Organization : The Conrad-Pearson Clinic

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Office-Based Procedures

ASC Office-Based Procedures

To whom it may concern,

I am a board-certified urologist practicing in a single specialty group in Germantown, Tennessee, a Memphis suburb. I am writing to express concern regarding proposed changes to Ambulatory Surgery Center (ASC) reimbursements. If ASC reimbursement is cut by applying office based procedure fee caps to current ASC payment schedules, most ASC s will be forced to close.

Current office based fee schedules no longer cover costs associated with the office based procedures (cystoscopy and prostate biopsy). Originally, all of these procedures were done exclusively in the hospital. Eventually, physicians began to perform these types of procedures in their offices because the hospital schedule became too congested to allow for these procedures to be done in a timely fashion. While there were start-up costs for the physician s office (equipment, disposables, and personnel) the professional fee reimbursement was initially high enough to offset these added expenses at the offiee facility. Over the years however, professional reimbursement has declined, and it has become impossible financially to continue to offer these expensive procedures in the office at current volumes. In the ASC setting, existing facility fee schedules allow for the center to cover the costs.

If ASC reimbursement is cut to the office based fee level (a schedule already recognized to be below costs of providing the service), then like the physician s office, the ASC will also stop providing the service. Areas already served by the ASC will once again have to rely on the hospital to provide these services. We already know that the hospitals are incapable of providing these high volume procedures in a timely fashion. The ASC has become the only vehicle to grant access for patients to these healthcare needs.

In the Urology ASC, prostate cancer, renal eancer, and bladder cancer are evaluated with ASC procedures of Cystoscopy (52000) and Prostate Biopsy (55700). These cancers account for approximately 40% of all cancers, and are currently evaluated primarily thru ASC s in most large communities. Losing access to these diagnostic procedures will cripple cancer management in our country. The best solution currently is to EXEMPT procedures that are eurrently on the ASC payment list from the office based payment CAPS.

If ASC s close, access to healthcare will be strictly limited in our country.

Submitter : **Date: 11/03/2006**

Organization : **Renal Support Network**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

Dialysis vascular access is the lifeline for people with Chronic Kidney Disease who need dialysis therapy. Unfortunately, it has been common practice for surgeons to implant a graft in lieu of a fistula due to disincentives between the payments for graft versus fistula. It has been well documented that people who have a fistula placed have better outcomes and fewer complications compared to those patients with grafts. Additionally, for a fistula to have enough time to mature, patients need a temporary catheter to receive dialysis.

Renal Support Network (RSN) supports Ambulatory Surgical Center reimbursement for dialysis access repairs to maintain our dialysis lifeline or to receive a temporary catheter so we may receive dialysis and not miss any scheduled treatments. Often times, due to a hospital s hectic surgery schedule, we are often not seen as a priority and it delays the repair or placement of our lifeline, which can lead to other complications such as a high potassium level or fluid overload. Allowing the patient to have access to a Ambulatory Surgical Center supports CMS' patient-centered approach to care by allowing patients to avoid the inconvenience of having to go to the hospital -- where we are often admitted overnight for procedures.

RSN supports the CPT Codes that will allow us to have access to more efficient quality care.

Also, RSN supports and applauds CMS' Fistula First initiative for the positive effects that it already has had in the kidney patient community.

Submitter : Mr. Jorge Carballo **Date:** 11/03/2006

Organization : The Ambulatory Surgical Centre of Miami

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

As the Administrator of The Ambulatory Surgical Centre of Miami located at 7500 SW 87th Ave Suite 101 Miami, FL 33173. I am writing to express my deep concern over Medicare s proposed rule to change the payment system for ambulatory surgery centers (ASC).

Our Center performs over 15,000 endoscopic procedures every year by 22 referring gastrenterologist, A significant number in which are scheduled screens for colorectal cancer. About 20% percent of our patients have Medicare benefits.

The current proposal to reduce ASC payment for endoscopic procedures by more than 25% by 2008 is absurd. The rates Medicare is suggesting are below the costs of performing these endoscopic procedures, including screening for cancer. This cut will have a draconian impact on our ambulatory endoscopy centers. Our practice will lose money on every Medicare patient that comes to our ASC. Our only choice will be to treat Medicare beneficiaries at the hospital, which is considerably more expensive. It will also cost our patients more in out of pocket expenses and will probably delay their care because our hospital does not have the capacity to handle this additional caseload on a timely basis.

This is unfair to our patients and a needless expense for Medicare. Medicare says that it has to set rates this low because Congress requires that the new payment system be budget neutral since many new procedures are going to be added to the ASC list of covered services in 2008. In order to pay for these new services, reimbursement for endoscopic procedures and many other surgical procedures will have to be cut.

The ASC is a safe, economic site for these services and is very popular with our elderly patients because of its convenience. It would be a disservice to these beneficiaries to adopt Medicare s proposal.

Congress needs to change its stand on budget neutrality to avoid this result. I know we can continue to provide services to Medicare patients in the ASC and save Medicare money if the reimbursement rules made sense. This proposal, however, does not pass that test.

Thank you for your careful consideration of this request. I urge you to convey these concerns to the Leadership of the Committees that handle Medicare and to encourage action to correct this issue this year.

Submitter : Dr. David Lamey **Date:** 11/03/2006

Organization : Orthopedic Surgery Center of Idaho

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attached

CMS-1506-P2-853-Attach-1.DOC

#853

ORTHOPEDIC
SURGERY
CENTER OF
IDAHO

1425 W River
Boise, ID 83702-6861

208-342-1932
208-336-1954 (fax)

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Proposed Medicare Payment Changes

My name is David Lamey, MD and I am a physician owner of the Orthopedic Surgery Center of Idaho in Boise, Idaho. Our ambulatory surgery center (ASC) offers orthopedic surgical services and has been providing high quality, patient centered, and cost effective interventional procedures and surgery since February 2002. Our 28 employees and 20 surgeons care for approximately 3200 patients a year (this includes over 340 Medicare beneficiaries) at our surgery center. I am taking this opportunity to offer our concerns regarding the payment rates for ASCs proposed by the Centers for Medicare and Medicaid Services (CMS).

In 2008, CMS essentially proposes to pay ASCs 38 percent less than what they pay a hospital for the exact same surgical procedure. This untenable price differential, which will widen further over time, is unrelated to the costs that ASCs incur in delivering services. It is driven entirely by the agency's narrow interpretation of budget neutrality requirements and will jeopardize the ability of many ASCs to continue to provide high quality surgical care to Medicare beneficiaries. (The ASC industry recommends that ASCs be paid at 75% of hospital rates.)

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient department services (HOPD) were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

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- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

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The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary.

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We strongly feel there is a better way to design the new ASC payment system, and would like the Centers for Medicare and Medicaid (CMS) to work with the ASC industry to find a more equitable system. Thank you for allowing us the opportunity to share our concerns.

Sincerely,

David Lamey, MD