

**CMS-0018-IFC-1**

**Submitter :** Dr. Ranjodh Gill

**Date:** 07/06/2006

**Organization :** VCU/MCV

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Finalize the recommended work RVU increases for evaluation and management services

**Submitter :** Dr. Timothy Young

**Date:** 07/07/2006

**Organization :** Dr. Timothy Young

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

As an internist, I strongly support the proposed changes in work values under CMS-1512-PN. It is becoming increasingly difficult to convince internists to go into primary care, as the complexity of the services increases but the compensation does not. Increasing the RVUs for E&M services as proposed would be a great help in this area. I strongly support this action.

CMS- 0018-IFC -3

Because the referenced comment number does not pertain to the subject matter for CMS- 0018-IFC, it is not included in the electronic public comments for this regulatory document.

CMS- 0018-IFC -4

Because the referenced comment number does not pertain to the subject matter for CMS- 0018-IFC, it is not included in the electronic public comments for this regulatory document.

**Submitter :** Ms. Shirlyn Adkins  
**Organization :** AANEM  
**Category :** Health Care Professional or Association

**Date:** 08/01/2006

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-0018-IFC-5-Attach-1.PDF

CMS-0018-IFC-5-Attach-2.DOC



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August 1, 2006

The Honorable Mark McClellan, MD, PhD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1512-PN  
PO Box 8014  
Baltimore, MD 21244-8012

Submitted electronically at <http://www.cms.hhs.gov/eRulemaking>

Dear Administrator McClellan:

The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) appreciates the opportunity to respond to the proposed rule "Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology" published in the *Federal Register* June 29, 2006.

#### **Five-Year Review of Work Relative Value Units**

The AANEM believes the proposed single-fiber electromyography (95872) relative value units (RVUs) of 2.0 inadequately represents the physician work required to perform the procedure. The AANEM respectfully requests that CMS accept the RVU of 3.00 approved by the Relative Value Update Committee (RUC).

CPT code 95872 had not been surveyed prior to the Five-Year Review, so the current RVU of 1.50 is from Harvard data. The AANEM believes that valuation for the code was incorrect because of a flawed mechanism and because of an anomalous relationship between code 95872 and the other codes in the family, as discussed below.

Single-fiber EMG is one of the most physically demanding and technically difficult studies that an electrodiagnostic physician can perform. The study is extremely time-consuming because it not only requires that the physician hold the single fiber needle electrode perfectly still for a minute or more at a time, but also requires the patient to remain very still and continuously activate a single muscle at a very low level of activation. If the patient stops activating the muscle while the physician is collecting a sample from a pair of muscle fibers, the entire collection process must be started over for that pair. In addition, many times during the process of conducting a test, a patient will move requiring the physician to re-study the same muscle fibers. The process is challenging for the physician as well. The physician must remain still and even the slightest movement by the physician requires that the process be repeated. Many physicians who perform single-fiber EMG even go so far as avoiding caffeine the day of the testing as the mild tremor associated with this substance makes the procedure even more difficult.

After collecting each sample from a pair of muscle fibers, the physician has to redirect the needle and search for a new pair of fibers to capture, which in itself can take several minutes at a time.

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**Executive Director**  
Shirlyn A. Adkins, JD

This same process is repeated until the physician has successfully collected at least 20 pairs of technically reliable recordings. Both the process of activating just one muscle at a time and not moving can be difficult for many patients to do consistently, making the procedure time-consuming and laborious. At the end of the study, between 1000 and 2000 waveforms must be individually analyzed for one unit of single-fiber EMG. Analyzing the data, often takes the physician more time than the collection process described above.

The survey conducted of 95872 found that pre, intra, and post time totaled approximately 95 minutes. Since this procedure is the most complex that electrodiagnostic physicians perform, a good comparison code in the family does not exist. This procedure is several fold more difficult, stressful, and time consuming than any other procedure performed by an electrodiagnostic physician. Use of single-limb EMG (95860) as the reference code in the survey, therefore was not an appropriate comparison code. Whereas single-limb EMG typically involves analysis of 100-200 waveforms and has a work RUV of 0.96, as stated above, single-fiber EMG requires analysis of 1000 to 2000 individual waveforms, ten-fold more than the commonly performed EMG reference procedure. The stress to the physician and the patient in performing single-fiber EMG are considerable. This test is often performed on the orbicularis oculi or frontalis muscles in the proximity of the globe of the patient eye; in addition, there is a substantial risk of hematoma with this prolonged procedure, resulting in some patients having a "black eye" at the end of the procedure even though a highly experienced electrodiagnostic physician performs the study. The work of this procedure has been grossly undervalued for many years. The code closest in comparison to single-fiber EMG (95872) in terms of physician work is likely deep brain stimulation (95978). Both procedures take a long time and require a high degree of technical competence. Deep brain stimulation has a total RUC time of 65 minutes and total RVU of 3.50 at the 75<sup>th</sup> percentile.

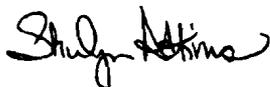
Only a few top physicians around the nation perform single fiber EMG procedure because of the intricate nature of the study. Typically these providers undergo additional training in this technique to assure quality patient care. Fewer than 1000 studies have been performed annually since 2003. The study is used primarily to diagnose myasthenia gravis. In light of the above information, the AANEM strongly believe there is sufficient justification to increase the RVU of single-fiber EMG to 3.00 at the 75<sup>th</sup> percentile in the final rule. The AANEM respectfully requests that the recommendation of the RUC be accepted.

#### **Practice Expense (PE) RVUs**

As you know, the American Medical Association is in the early stages of conducting a multi-specialty physician practice survey to assist CMS in determining the distribution of practice expense payment under the Resource-Based Relative Value Scale (RBRVS). According to the current timeline, data will be submitted to CMS in 2008 with the expectation that the data would be incorporated into the physician payment schedule determinations on January 1, 2009. The AANEM recommends that implementation of the new PE methodology be postponed until this survey has been completed so the methodology is based upon the data that will be more accurate than that from the Clinical Practice Expert Panels.

Thank you for your attention to these matters. The AANEM looks forward to working with CMS, the RUC, and other physician organizations to assure the proper valuation of physicians' services.

Sincerely,



Shirlyn Adkins, JD  
Executive Director

**CMS-0018-IFC-6      Identification of Backward Compatible Version of Adopted  
Standard for E- Prescribing and the Medicare Prescription Drug  
Program (Version 8.1)\*\*\***

**Submitter :** Dr. Steven Mueller

**Date & Time:** 08/07/2006

**Organization :** Steven A Mueller MD INC.

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

To Whom it may concern: I am an anesthesiologist practicing in Oklahoma City Oklahoma since 1983. I am seriously concerned over the proposal to cut medicare anesthesia reimbursement by an additional 5-6% to increase payments to primary care physicians. CMS has in the past acknowledged that Anesthesiology has been undervalued by the current Relative Value system which is flawed and has been in place since the 90's. We have been told that changes are hard to make because the budget has to be neutral and for us to get the increase another specialty would have to suffer. So now you are going to make us suffer when we are already having trouble caring for medicare enrollees. In Oklahoma we are already reimbursed at the lowest rate of all states when our malpractice insurance rates have risen by 100% over the past 2-3 years. I am currently being reimbursed at approximately 30% of what a commercially insured non medicare patient pays. In 1983 when I started practice I collected 50% more than I do now from Medicare patients. I fear that there will be a mass exodus of anesthesiologists from the medicare system if these ridiculous reimbursement cuts are allowed. Our senior citizens deserve outstanding medical care but if the manpower is not available to care for them we will have a real crisis. PLease stop these cuts in Anesthesia reimbursement and fund us at level that is comparable to other medical specialties.

CMS- 0018-IFC -7

Because the referenced comment number does not pertain to the subject matter for CMS- 0018-IFC, it is not included in the electronic public comments for this regulatory document.

CMS- 0018-IFC -8

Because the referenced comment number does not pertain to the subject matter for CMS- 0018-IFC, it is not included in the electronic public comments for this regulatory document.

**CMS-0018-IFC-9      Identification of Backward Compatible Version of Adopted  
Standard for E- Prescribing and the Medicare Prescription Drug  
Program (Version 8.1)\*\*\***

**Submitter :** Mr. Stephen Lieber

**Date & Time:** 08/22/2006

**Organization :** HIMSS

**Category :** Other Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-0018-IFC-9-Attach-1.DOC



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[www.himss.org](http://www.himss.org)

August 22, 2006

The Honorable Mark McClellan, MD, Ph.D.  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Dr. McClellan:

The Healthcare Information and Management Systems Society (HIMSS) is pleased to submit our comments regarding the CMS' Proposed Rule "*Identification of Backward Compatible Version of Adopted Standard for E-Prescribing and the Medicare Prescription Drug Program (Version 8.1)*" CMS **Reference Number: CMS-0018-IFC posted on June 23, 2006**). As an organization, HIMSS is committed to achieving the benefits healthcare information and management systems provide to care delivery and process improvement throughout the healthcare continuum. The recent unification of HIMSS membership with the Association for Electronic Health Care Transactions (AFEHCT) combines the subject matter expertise of AFEHCT with the organizational strength of HIMSS to achieve the most effective voice for influencing policies and procedures in electronic commerce and business transactions in healthcare

Prior to its merging with HIMSS in June 2006, AFEHCT had engaged in a dialogue with CMS and HHS staff to identify potential steps to streamline the standards update process. To that end, the following HIMSS/AFEHCT position includes many of the comments identified during those previous meetings.

HIMSS/AFEHCT supports the applicability of the interim final rule to the specific transaction versions mentioned in the Interim Final Rule (IFR):

*Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8.1 (hereafter referred to as "Version 8.1 of the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard") as a backward compatible update of the adopted Version 5.0.*

HIMSS/AFEHCT appreciates the limits placed on HHS by the Administrative Procedure Act, and the positions taken by HHS. Citing the Administrative Procedure Act, HHS representatives have often contended that mandatory compliance requires the standard to be promulgated via the Notice of Proposed Rule Making (NPRM) and Final Rule process. If compliance is voluntary and the updated version of the already adopted standard is **backward compatible** with the prior version, the NPRM and Final Rule process could be avoided.

As we understand the issue, references or components of a definition of backward compatibility contained in the IFR include:

- Changes to updated version are not substantive
- Impose (or mandate) no new requirements on the public
- Retain, at a minimum, the full functionality of the version(s) previously adopted in regulation, (without alteration until the prior version is officially retired) which would permit the successful completion of the applicable transaction(s) with entities that continue to use the older version(s)

HIMSS/AFEHCT finds the concept of “backward compatibility,” as defined in this IFR, problematic as it will have a very narrow and limited scope of applicability. We are concerned that the government is headed down a difficult path in trying to make backward compatibility “the criteria” for determining if an NPRM is used. As standards evolve they must be modified continually to more accurately conform to business needs for all stakeholders. Modifications are likely to impact business rules, which may place new requirements on existing functions or alter business rules from prior versions. New business functions also may be necessitated and written as required in the Implementation Specifications to meet changing business or regulatory requirements; and some obsolete functions or data requirements may need to be removed.

An example of this is the compatibility concerns when transitioning from the X12/837 implementation guides for claims transaction version 4010 to version 5010. One of the major deficiencies in versions prior to 5010 was the lack of provider definition and structure. Modifications included in version 5010 of the implementation guides support transactions that enable the sender to present data in the same structure without regard to the intended recipient system. There are several structure changes in version 5010 that also fit into the areas of content and technical changes, to include modifications to accommodate an Oxygen Certificate of Medical Necessity and ICD10-CM and ICD10-PCS. Therefore, version 5010 is not backward compatible with 4010.

HIMSS/AFEHCT recognizes that in most instances, modifications are intended to strengthen a standard to keep pace with changes in the business requirements for financial and administrative transactions and other emerging needs; and that such modifications have been heavily vetted by the industry through an SDO’s own public commenting process. We believe that such modifications need to be made available to the industry more quickly than is currently permitted with the NPRM and Final Rule process, and the backward compatibility is one effective approach, but will have limited opportunities. Therefore, we also believe that HHS must look for and support other effective alternatives to the backward compatibility strategy.

We also realize that this is a statutory issue that may need congressional assistance. To that end, we are monitoring the progress of H.R. 4157, the Health Information Technology Promotion Act of 2006, as it moves into the House and Senate Conference Committee process. H.R.4157 will require that *Federal Register* notification be made of SDO public comment opportunities that will result in full industry participation, as is achieved by the NPRM process.

Further, directing public comments to the SDO public comment period rather than waiting for an NPRM process solves a significant problem that the SDOs have been concerned about and have shared with CMS, specifically the timing of modifications that may be required to a standard as a result of public comments, which would result in further implementation delays (potentially another 12-18 months) as the SDO develops an updated version of the standard or Implementation Specification to respond to a comment. Using the SDO public comment period

avoids the problem of having a redundant comment period with the NPRM process which would force a new versions to be developed rather than making these changes while the standard or implementation specification is still in development, and before the standard is published to be promulgated.

Conclusion:

HIMSS/AFEHCT appreciates the opportunity to comment on the question of *Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8.1 (hereafter referred to as "Version 8.1 of the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard") as a backward compatible update of the adopted Version 5.0, as outlined in the proposed IFR. We support the applicability of the IFR to these specific transaction version changes.*

However, HIMSS/AFEHCT has strong concerns about the applicability of backward compatibility in other standards processes. We need to find a solution to the NPRM and Final Rule public comment processes to reduce the level of unnecessarily duplication. Beyond the NCPDP SCRIPT Standard referenced in the IFR, we are concerned that more dialogue needs to occur before heading down the path of using backward compatibility as "the criteria" for administering changes in the standards development process. HIMSS/AFEHCT looks forward to further discussion on this topic. If you have any additional questions please contact Mr. Thomas M. Leary, Director, Federal Affairs, [tleary@himss.org](mailto:tleary@himss.org), or 703.837.9814.

Sincerely,



H. Stephen Lieber, CAE  
President and CEO  
HIMSS



George T. Hickman, CPHIMS, FHIMSS  
Sr. Vice President and Chief Information Officer  
Albany Medical Center

