Submitter : Dr. Brett Coldiron **Date:** 08/21/2006

Organization : American Academy of Dermatology Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2267-Attach-1.PDF

#2267

American Academy of Dermatology Association
Physicians Dedicated to Excellence in Dermatology

Phone
Fax
Web Site

Diane R. Baker, MD, FAAD
William P. Coleman, III, MD, FAAD
Henry W. Lim, MD, FAAD

Stephen P. Stone, MD, FAAD
David M. Pariser, MD, FAAD
Mary E. Maloney, MD, FAAD
Ronald A. Hendricks, CAE

August 21, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
C5-25-25
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **CMS-1512-PN**

Dear Administrator McClellan:

On behalf of the 15,000 members of the American Academy of Dermatology Association (AADA), I appreciate the opportunity to submit written comments regarding the five-year review of work relative value units under the physician fee schedule and proposed changes to the practice expense methodology. As advocates for dermatologists and their patients, we support modifications to the current physician fee schedule to ensure fairness and continued beneficiary access to quality, specialty health care services.

Discussion of Comments – Dermatology and Plastic Surgery
There were forty six dermatology codes placed by CMS on the American Medical Association (AMA) Relative Values Update Committee (RUC) 5 Year Review (5YR) List. This list included all of the benign and malignant excision codes (114XX and 116XX) as well as two key Mohs codes (17304-17305). The CMS rationale for placing these codes on the RUC 5YR list is: 1) physician work time is still based on the Hsaio/Harvard Study in 1992; or 2) increase in volume of procedures submitted to Medicare for payment. AMA RUC protocol required that AADA as well as other specialty societies e.g., American College of Surgeons, American Association of Otolaryngology- Head and Neck Surgeons) with significant utilization of these codes survey each code in order to justify the current level of physician time and work intensity.

We are pleased that current work values were confirmed for the benign and malignant excisions. However, the survey data collected by the AADA and the American College of Mohs Micrographic Surgery and Cutaneous Oncology (ACMMSCO) also met RUC 5 YR requirements and supported a moderate increase to the current level of physician time and work intensity for Mohs surgical procedures. However, the AMA RUC 5 YR Work Group recommended that the Mohs Micrographic Surgery codes go back to AMA CPT for clarification. AADA and ACMMSCO continue to work with AMA CPT and AMA RUC to bring this process to completion.

The Academy is disappointed that CMS has not accepted the AMA RUC recommendations for valuation of CPT 17004. The Academy supports the AMA RUC recommendation for a decrease in physician work from 2.79 PW/RVUs to 1.80 PW/RVUs for CPT 17004 which appropriately values the surveyed code in relation to CPT 17111. The AMA RUC reviewed CPT 17004 as part of its identification of rank order anomaly process. The RUC identified this procedure as being overvalued after reviewing CPT 17003 - *Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; second through 14 lesions, each (List separately in addition to code for first lesion).*

CMS states "For CPT 17004, we believe that the work associated with benign and premalignant lesions is comparable and therefore, should be more similar to CPT 17111 - Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum or milia; 15 or more lesions (PW/RVU=0.92)."

In the AMA RUC review of this procedure, it was evident that the work associated with benign and pre-malignant lesions was not comparable. This was reflected in the RUC action of recommending that the CPT Editorial Panel modify the CPT descriptors for these procedures to reflect that all procedures performed on pre-malignant lesions should be addressed in the 17000 family of codes, while all procedures performed on benign lesions (other than skin tags or cutaneous vascular lesions) would be addressed in the 17110 family of codes. Furthermore, the RUC noted that the surveyed code 17004 requires greater mental effort and judgment, technical skill, intensity and time in comparison to CPT 17111.

Other Issues Under the 5-Year Review – Budget Neutrality

The proposed notice requires budget neutrality adjustments as a result of changes in relative value units (RVU) from the five-year review process and other payment policy revisions. Application of the budget neutrality adjustment to the conversion factor would impact all physician services, whereas the application of the budget neutrality adjustment to the work RVUs would impact only those services that have physician work RVUs.

As noted in the proposal, CMS believes it is more equitable to apply the adjustment across services that have work RVUs, and is therefore proposing a budget neutrality adjustor that would reduce all work RVUs by an estimated 10 percent to meet the budget neutrality provisions of the Medicare law. The Academy strongly disagrees with applying a budget neutrality adjustment to the work RVUs. We instead urge CMS to apply the budget neutrality adjustment to the 2007 conversion factor rather than the work RVUs. In the past, application of the budget neutrality adjuster to the work RVUs has led to confusion in the Medicare and private payer systems and confounded the work of the RUC. For these reasons, CMS itself has had to reverse itself and revert to applying the adjustor to the conversion factor. Rather than repeating the mistakes of history, CMS is urged to learn from these past examples by avoiding the confusion and applying the adjuster to the conversion factor in the final rule for implementing the 2007 Medicare physician fee schedule.

Furthermore, in a feature of the proposal sure to exacerbate the problems with the application of the budget neutrality adjustment in this proposal, an adjustment is applied *three times* in the newly-proposed PE methodology – to the direct inputs, to the indirect allocations, and also as a final step. The Academy seeks clarification on the impacts of applying three separate budget neutrality adjustments in the new methodology instead of simply one final step.

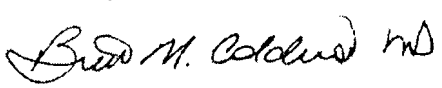
Practice Expense

The Academy appreciates the CMS proposal to incorporate our practice expense supplemental survey data in the 2007 fee schedule. Our Association dedicated considerable staff and physician volunteer time and significant financial resources to submitting supplemental survey data, as provided by the Balanced Budget Refinement Act of 1999 (BBRA) and requested by CMS. Incorporating this data into the CY2007 fee schedule will increase the accuracy in determining the PE RVUs for the services our members provide, as well as improving the overall accuracy of the practice expense component of the fee schedule. Again, we appreciate CMS at last including the supplemental survey data into the proposed rule and request that the data be implemented in the final rule.

As you know, the AMA is sponsoring a multi-specialty supplemental study of practice expense costs. The AADA has already agreed to participate in and contribute to this additional practice expense survey. However, we are deeply concerned that the design and structure of the new survey be in compliance with all of the criteria established for the specialty specific practice expense supplemental surveys accepted by CMS. Additionally, the new multi-specialty practice expense survey results must be held to the same standard relating to the level of precision as the supplemental surveys already accepted by CMS.

Thank you for the opportunity to comment on this proposed notice. For further information, please contact Jayna Bonfini at jbonfini@aad.org or 202-842-3555 or Norma Border at nborder@aad.org or 847-330-0230.

Sincerely,



Brett Coldiron, MD, FAAD
Chairman, Health Care Financing Committee

Cc: Stephen P. Stone, MD, FAAD, President
Diane R. Baker, MD, FAAD, President-Elect
David M. Pariser, MD, FAAD, Secretary-Treasurer
Ronald A. Henrichs, CAE, Executive Director and CEO
Daniel Siegel, MD, FAAD, AADA RUC Representative
Michael Bigby, MD, FAAD, AADA RUC Representative
Bruce Deitchman, MD, FAAD, AADA RUC Representative

John Zitelli, MD, FAAD, Chair, AADA CPT Committee
John D. Barnes, Deputy Executive Director
Judy Magel, PhD, Senior Director, Practice, Science & Research
Laura Saul Edwards, Director, Federal Affairs
Cyndi Del Boccio, Director, Executive Office
Jayna Bonfini, Assistant Director, Federal Affairs
Norma Border, Senior Manager, Coding and Reimbursement
Vernell St. John, Senior Coding and Reimbursement Specialist
Peggy Eiden, Coding & Reimbursement Specialist

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

Suite 700
1101 Vermont Avenue NW
Washington, DC 20005-3570

Tel. 202.737.6662
Fax 202.737.7061
http://www.aao.org

Federal Affairs Department

August 21, 2006

via Electronic Mail
The Honorable Mark McClellan, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, Maryland 21244-8017

Re: CMS-1512-PN; Medicare Program; Five Year Review of Work Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan:

On behalf of the American Academy of Ophthalmology (Academy), I am pleased to submit comments on the above proposed rule published in the Federal Register on June 29, 2006. The Academy is the world's largest organization of eye physicians and surgeons with more than 27,500 members. Over 16,000 of our members are in active practice in the United States. Our comments relate to the results for ophthalmology from the Five Year Review of Work Relative Value Units (RVU); the proposed application of the budget neutrality adjustment to Work RVUs rather than the conversion factor; the application of the increased work RVUs to the post-op global office visits; the use of supplemental survey data in the practice expense methodology; the proposed adoption of the Indirect Practice Cost Index and the use of clinical labor for codes with low or no physician work for indirect practice expense calculations.

Five Year Review:

Work RVUS:
The Academy reviewed in detail the codes submitted by CMS for RUC review. While we believe that the RUC Five Year Review Work Group was fair in its consideration of the ophthalmic codes, we are disappointed at the decrease in value for cataract surgery: CPT 66984. Through technical innovation, cataract surgery has become one of the safest, most beneficial and most cost effective surgical treatments in all of medicine. Operating on either the first or second eye has been shown to improve patient functioning and quality of life (Javitt). Cataract surgery can ameliorate the age-related decline in general functioning (Mangione) and is one of the major components of regular eye care in seniors that is associated with a lower likelihood of

developing new limitations in activities of daily living. New technology has shortened the intra-operative time when compared to survey data in 1997, but the use of such technology requires much greater technical skill. We hope this downward reimbursement "reward" for improved patient outcomes and decreased patient morbidity as a result of advances in technology does not lead to a decrease in research and innovation in medical care.

The Academy is disappointed with the RUC and CMS decision to unlink the long standing relationship of the Ophthalmology Examination Codes (92002-92014) to the Evaluation and Management (E/M) Codes. In the first Five Year Review of Work Values, the Eye Codes were linked to corresponding E/M services by the RUC Work Group whose recommendations were accepted by the full RUC and CMS. CMS reaffirmed this relationship in the Federal Register Vol.61.No. 87/May 3, 1996:

> "The RUC agreed that a permanent link should be established between the ophthalmologic eye examination codes and the evaluation and management services; The RUC recommended that the following relationship be established for assigning work RVUs to the ophthalmologic codes:
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> We agree with the relationships in the RUC recommendation."

We agreed to this change for the 1997 PFS (although it was associated with a decrease in the WRVU for these services) because the linkage and relativity between E/M WRVUS and ophthalmology examination code WRVUS was described as "permanent". That promise has now been broken without evidence being presented to suggest that the work of the Eye Codes has decreased in relation to E/M codes in the last ten years. Work values for E/M codes were increased primarily because there was general recognition that the patients have become more complex: older, sicker and on more medications than in the early 1990's. We agree with that assessment and would point out that, because we take care of these same patients, our patients have also become older, sicker and more complex. Many of the new medications used by the internists and other practitioners have significant ocular side effects. Patients being considered for surgery have more medical issues than in the past that must be considered and the time to coordinate care with their primary care physicians has increased.

In addition to the increased medical complexity of the patients, the actual work of the intermediate and comprehensive, new and established, ophthalmology examination codes has increased in exactly the same ways that E/M codes have been affected by advances in the treatment of many common ocular diseases. Since 1996, when the survey of the ophthalmology

examination codes was performed, there has been an explosion in the recommended treatment and counseling of many ophthalmic entities.

In the area of diabetic retinopathy and macular degeneration, new Academy Preferred Practice Patterns (PPPs) have dramatically increased the content and complexity of eye code visits for diabetic retinopathy and AMD (age related macular degeneration). The publication of the Ocular Hypertension Treatment Study has increased the counseling of glaucoma and ocular hypertensives. There is certainly no evidence to suggest that the eye codes have lost their relative physician work relationship to the E/M codes as adopted by the RUC and CMS in 1996.

Throughout the current Five Year Review, CMS and the RUC have recommended increases in the codes linked to E/M services. For example, all the post-op visit codes in 90-day global surgical codes were to receive the full E/M increase. For these reasons we urge CMS to reaffirm the linkage of the ophthalmology examination codes to the E/M codes and increase those values to reflect the proposed increases in E/M services. If this is not possible, we suggest that the work values prior to the linkage in 1996 be restored since they were lowered during the first Five Year Review of Work values to facilitate the linkage process.

We commend CMS for the adoption of the RUC proposed increases in other ophthalmic codes identified in the notice.

Application of the Increased E/M WRVUS to the 10-and 90-day global codes:

The Academy fully agrees with the RUC recommendation to apply the full recommended E/M WRVUS to the services included in the 10- and 90-day global codes. This has been a long standing policy of RUC and CMS and we are pleased with the continuation of this policy. However, it is apparent that CMS failed to adopt the RUC recommendation to use the full and not a discounted value for these services and we would ask that the agency make the mathematical correction in the Final Rule in November.

Budget Neutrality

The Omnibus Budget Reconciliation Act of 1989 requires that increases or decreases in relative value units (RVUS) for a year may not cause the amount of expenditures for the year to differ more than $20 million from the expected expenditures without the new RVU changes. For 2007, CMS is proposing to effect the statutorily mandated budget neutrality adjustment by developing a new work adjuster. The AAO strongly objects to this approach and recommends that budget neutrality be applied to the final conversion factor and not work relative value units.

There have been two mechanisms adopted by CMS in the past to deal with budget neutrality: with a work adjuster or applying budget neutrality to the conversion factor. In 1997, CMS initially established a work adjuster which

was vigorously opposed by the RUC. This policy was abandoned within two years and budget neutrality adjustments have been made since then in the conversion factor. When explaining this change, CMS stated:

> "We did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUS to determine a payment amount that matched the amount actually paid by Medicare." (Federal Register, Vol. 68, No. 216, Pg. 63246)

We agreed with the CMS decision at that time and are bewildered by the change proposed to policy. CMS states in the June 29, 2006 Federal Register that they are adopting a work adjuster because they believe it is more equitable to apply budget neutrality reduction in the fee schedule directly to codes code involved in the Five Year of Work Values. The Academy disagrees. Fewer than 500 codes were involved in the Five Year Review and the other 7,000 codes will be penalized only because they have WRVUs. We understand CMS's desire to consider codes with no or low WRVUs, but these are mostly technical imaging codes which are among the fastest growing in terms of volume in the Medicare fee schedule. Payment for many of these codes will be cut in January 2007 as part of the implementation of the Deficit Reduction Act of 2006.

In addition, the decision to adopt a work adjuster will adversely affect codes with a higher ratio of work to practice expense and PLI RVUs. By protecting codes with little or no physician work, CMS is further reducing payment for those services felt by the RUC and other health policy decision makers to be currently undervalued: E/M codes and complex surgical procedures. For example, after vigorous discussion, the RUC adopted large increases in the WRVUs of the E/M codes echoing the position of MedPAC. By applying a work adjuster, only 23 of 35 cognitive codes will actually achieve increases, whereas the RUC recommended significant increases to 33 of 35 codes. We do not believe this is good public policy to deny increased payment to services felt to be undervalued.

Additionally, the WRVUs are used to determine the practice expense RVUs. It appears CMS has proposed to use the discounted work RVUs resulting from the work adjuster to determine the indirect practice expenses. This allows CMS to cut physicians twice. We feel the full value of the WRVUs should be used in the practice expense calculations.

Practice Expense

The Academy strongly opposes CMS adoption of the policies outlined in the June 29, 2006 rule as inequitable and poor policy. Obtaining current and accurate indirect practice expense data is a crucial issue facing Medicare. MedPAC has consistently raised equity concerns about using the new specialty data for only some specialties while 1999 SMS survey data is used

for others. We are very pleased that CMS and AMA are exploring the development of a new survey and would hope that such new data could be incorporated as soon as 2008. If new specialty wide survey data is not available for 2008, we recommend that specialties be able to continue to submit new data.

We will focus our comments on six aspects of the new practice expense methodology. These comments deal with the adoption of supplemental survey data, the calculation of equipment expense, the use of clinical labor costs for indirect practice expense allocation for codes with low or no physician work and the use of the discounted WRVUs for indirect practice expense calculations.

1) *Use of Supplemental Survey Data*:

We are very concerned with the distortions introduced into the Medicare fee schedule by the adoption of supplemental survey from several specialties. The validity of the method used by CMS to integrate these new values with the current SMS data used by the remaining specialties is suspect. The supplemental survey data submitted by radiology, cardiology, urology, radiation oncology, dermatology, allergy, and gastroenterology increased the PE/HR values of those specialties between 83% and 202%. It is unreasonable to assume that only these specialties had a significant increase in PE and therefore inappropriate to allow these new data to be considered for some specialties in computing the PE values when the practice expense payments of all other physicians are based on the original SMS survey data from 1999. We urge CMS to not utilize these data until the new data from the AMA Multi-Specialty Practice Expense Survey is gathered. If the data must be used in 2007, the AAO urges a blending of the new and old SMS data for these specialties to minimize the huge distortions in the Medicare fee schedule in 2007 that would result. With practice expenses accounting for over 40% of physician payments and CMS acknowledging that it is only paying a fraction of physician's overhead it is important that the practice expense distribution be done correctly.

We ask that CMS acknowledge the erroneous statement in the notice of assuming the AMA's SMS survey data was deflated to 1997 values when actually it reflected 1995 data.

2.) *Equipment Assumptions:*

We have grave concerns with CMS' failure to address the issue of the cost of capital equipment and utilization percentages. Currently CMS utilizes an interest rate of 11% in pricing medical equipment. This cost of capital is a legitimate business expense, but 11% does not reflect current market conditions. We urge CMS to change the 11% cost of capital to reflect a market competitive rate.

- CMS currently assumes that all equipment is utilized 50% of the time. We believe that CMS must select utilization figures more closely related to the type of equipment. The 50% figure does not reflect the current utilization of expensive imaging equipment as pointed out by MedPAC and others. We urge CMS to consider a higher utilization rate of 75% as proposed in the past. For other categories of equipment such as lasers, a much lower utilization rate of 10-20% is justifiable. CMS should develop and provide a mechanism for specialties to provide data to justify the appropriate rate.

3.) The Use of Clinical Labor Costs for Codes with Low or No Physician Work:

We applaud CMS' initiative in removing the Zero Work Pool. However, the use of clinical labor cost in the indirect practice expense allocation for services where the clinical labor costs are greater than the physician work is a mistake. If there is no physician work in a code, then there is no physician work. The clinical labor costs are already accounted for in the direct practice expenses. The proposed method would overvalue the practice expenses for these codes by arbitrarily inflating the indirect costs. We urge CMS to use only physician work for this step in the calculation of indirect practice expenses. The Academy objects to the adoption of "fudge factors" like this to protect the value of classes of codes which might face future cuts.

4.) Use of Discounted Work RVUs in Indirect Practice Expense Calculations:

It appears that CMS has used WRVUs calculated after budget neutrality adjustments. This would lead to inaccurate payments of practice expenses and is just another reason not to apply budget neutrality as a work adjuster. We urge CMS to use correct work RVUs that have not undergone budget neutrality adjustments. We suggest that CMS use current RUC and CMS values to include the results of the third Five Year Review.

5.) Specialty weighting of PCI

The Proposed Notice states that the Secretary has determined that PE RVUs should reflect the resources required to perform a service for a "typical" patient. Therefore, we suggest that the approach of basing the specialty adjusted weight on a weighted average of all specialties providing a service is flawed. Rather, we suggest that the weight should be based on the weight of the specialty or specialties that represent 95 percent of the total utilization of the appropriate CPT code and modifier. Otherwise, the practice expense (PE) related payment is impacted by the practice costs of specialties who do not represent the "typical" patient.

We believe that this adjustment will be particularly important for codes that are billed by a wide range of specialties that typically are not performing the entirety of the service. For example, CPT code 66894 which describes cataract surgery is billed by 19 specialties, even though almost all of the

procedures are performed by ophthalmologists. Similarly, CPT codes 92012 and 92014, which describe eye exams for an established patient, are billed by 29 and 31 specialties respectively, although ophthalmologists and optometrists account for more than 99 percent of the utilization.

The specialty-based weights impact the PE RVU calculation because the indirect costs are determined based on the direct cost estimate at the procedure level and the ratio of direct and indirect costs at the practice level. AAO has analyzed the proposed PE RVUs and determined that an alternative approach described below would correct some of the anomalies that result from the inclusion of specialties that are not typically related to a procedure code. In addition, we believe that the utilization data used in calculating the weighted values for CPT 66984 are incorrect and do not reflect the clinical reality and the roles of ophthalmologists and optometrists in the service.

The utilization data contained on the CMS website indicates that 85.4 percent of the utilization of CPT 66984 is associated with an ophthalmologist while another 14.2 percent is associated with an optometrist and 0.4 percent is associated with some 17 other specialties. This belies the clinical reality that the surgery is exclusively provided by ophthalmologists. Optometrists are involved only during the post-procedure period for a number of post-operative visits and not involved in the preservice, intraservice, and day of service discharge portions of the procedure. The clinical reality could be confirmed if the utilization data at the CPT code level also included modifiers since most optometrists will bill for CPT code 66984 with the "-54" modifier to indicate the care associated with the post- operative period. The published PE RVU appears to reflect the 0.854 and 0.142 for ophthalmology and optometry, respectively with an additional small weight used to distribute the 0.4 percent associated with the other 17 specialties.

AAO suggests that the PE RVU for CPT 66984 be based solely on ophthalmology utilization, or if a weighting of the optometry practice costs is necessary, that the weight assigned reflect either the clinical reality of the service provided by optometry affect only the postoperative portion of the service. The result will be a PE RVU which better approximates the resources needed to perform this service.

6.) Summary

In general, the Academy is very disappointed with the currently proposed hybrid practice expense methodology incorporating both bottom up and top down principles. Our understanding, after attending the CMS sponsored February "Town Hall" in Baltimore, was that the new practice expense methodology was going to adopt a bottom up methodology and was to be more transparent by utilizing the comprehensive and complete data on direct practice expenses developed by the RUC PEAC and PERC committees working with CMS staff. While a significant improvement over the 2005 proposed rule, the proposed methodology for practice expenses is still confusing, lacks transparency, manipulates policy to reward some services

with little or no physician work, distorts the Medicare physician fee schedule and is frankly poor public policy.

The Academy appreciates your consideration of these comments. We would be glad to provide any additional supporting documents that you require and would be pleased to meet with you to discuss any of these issues in greater detail.

Sincerely,

Michael X. Repka, MD

Submitter : Dr. Michael Repka **Date:** 08/21/2006

Organization : American Academy of Ophthalmology

Category : Health Care Professional or Association

Issue Areas/Comments

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See Attachment

CMS-1512-PN-2268-Attach-1.PDF

#2268

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

Suite 700
1101 Vermont Avenue NW
Washington, DC 20005-3570

Tel. 202.737.6662
Fax 202.737.7061
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Federal Affairs Department

August 21, 2006

via Electronic Mail
The Honorable Mark McClellan, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, Maryland 21244-8017

Re: CMS-1512-PN; Medicare Program; Five Year Review of Work Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

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The Omnibus Budget Reconciliation Act of 1989 requires that increases or decreases in relative value units (RVUS) for a year may not cause the amount of expenditures for the year to differ more than $20 million from the expected expenditures without the new RVU changes. For 2007, CMS is proposing to effect the statutorily mandated budget neutrality adjustment by developing a new work adjuster. The AAO strongly objects to this approach and recommends that budget neutrality be applied to the final conversion factor and not work relative value units.

There have been two mechanisms adopted by CMS in the past to deal with budget neutrality: with a work adjuster or applying budget neutrality to the conversion factor. In 1997, CMS initially established a work adjuster which

was vigorously opposed by the RUC. This policy was abandoned within two years and budget neutrality adjustments have been made since then in the conversion factor. When explaining this change, CMS stated:

> "We did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUS to determine a payment amount that matched the amount actually paid by Medicare." (Federal Register, Vol. 68, No. 216, Pg. 63246)

We agreed with the CMS decision at that time and are bewildered by the change proposed to policy. CMS states in the June 29, 2006 Federal Register that they are adopting a work adjuster because they believe it is more equitable to apply budget neutrality reduction in the fee schedule directly to codes code involved in the Five Year of Work Values. The Academy disagrees. Fewer than 500 codes were involved in the Five Year Review and the other 7,000 codes will be penalized only because they have WRVUs. We understand CMS's desire to consider codes with no or low WRVUs, but these are mostly technical imaging codes which are among the fastest growing in terms of volume in the Medicare fee schedule. Payment for many of these codes will be cut in January 2007 as part of the implementation of the Deficit Reduction Act of 2006.

In addition, the decision to adopt a work adjuster will adversely affect codes with a higher ratio of work to practice expense and PLI RVUs. By protecting codes with little or no physician work, CMS is further reducing payment for those services felt by the RUC and other health policy decision makers to be currently undervalued: E/M codes and complex surgical procedures. For example, after vigorous discussion, the RUC adopted large increases in the WRVUs of the E/M codes echoing the position of MedPAC. By applying a work adjuster, only 23 of 35 cognitive codes will actually achieve increases, whereas the RUC recommended significant increases to 33 of 35 codes. We do not believe this is good public policy to deny increased payment to services felt to be undervalued.

Additionally, the WRVUs are used to determine the practice expense RVUs. It appears CMS has proposed to use the discounted work RVUs resulting from the work adjuster to determine the indirect practice expenses. This allows CMS to cut physicians twice. We feel the full value of the WRVUs should be used in the practice expense calculations.

Practice Expense

The Academy strongly opposes CMS adoption of the policies outlined in the June 29, 2006 rule as inequitable and poor policy. Obtaining current and accurate indirect practice expense data is a crucial issue facing Medicare. MedPAC has consistently raised equity concerns about using the new specialty data for only some specialties while 1999 SMS survey data is used

for others. We are very pleased that CMS and AMA are exploring the development of a new survey and would hope that such new data could be incorporated as soon as 2008. If new specialty wide survey data is not available for 2008, we recommend that specialties be able to continue to submit new data.

We will focus our comments on six aspects of the new practice expense methodology. These comments deal with the adoption of supplemental survey data, the calculation of equipment expense, the use of clinical labor costs for indirect practice expense allocation for codes with low or no physician work and the use of the discounted WRVUs for indirect practice expense calculations.

1) *Use of Supplemental Survey Data*:

We are very concerned with the distortions introduced into the Medicare fee schedule by the adoption of supplemental survey from several specialties. The validity of the method used by CMS to integrate these new values with the current SMS data used by the remaining specialties is suspect. The supplemental survey data submitted by radiology, cardiology, urology, radiation oncology, dermatology, allergy, and gastroenterology increased the PE/HR values of those specialties between 83% and 202%. It is unreasonable to assume that only these specialties had a significant increase in PE and therefore inappropriate to allow these new data to be considered for some specialties in computing the PE values when the practice expense payments of all other physicians are based on the original SMS survey data from 1999. We urge CMS to not utilize these data until the new data from the AMA Multi-Specialty Practice Expense Survey is gathered. If the data must be used in 2007, the AAO urges a blending of the new and old SMS data for these specialties to minimize the huge distortions in the Medicare fee schedule in 2007 that would result. With practice expenses accounting for over 40% of physician payments and CMS acknowledging that it is only paying a fraction of physician's overhead it is important that the practice expense distribution be done correctly.

We ask that CMS acknowledge the erroneous statement in the notice of assuming the AMA's SMS survey data was deflated to 1997 values when actually it reflected 1995 data.

2.) *Equipment Assumptions:*

We have grave concerns with CMS' failure to address the issue of the cost of capital equipment and utilization percentages. Currently CMS utilizes an interest rate of 11% in pricing medical equipment. This cost of capital is a legitimate business expense, but 11% does not reflect current market conditions. We urge CMS to change the 11% cost of capital to reflect a market competitive rate.

- CMS currently assumes that all equipment is utilized 50% of the time. We believe that CMS must select utilization figures more closely related to the type of equipment. The 50% figure does not reflect the current utilization of expensive imaging equipment as pointed out by MedPAC and others. We urge CMS to consider a higher utilization rate of 75% as proposed in the past. For other categories of equipment such as lasers, a much lower utilization rate of 10-20% is justifiable. CMS should develop and provide a mechanism for specialties to provide data to justify the appropriate rate.

3.) The Use of Clinical Labor Costs for Codes with Low or No Physician Work:

We applaud CMS' initiative in removing the Zero Work Pool. However, the use of clinical labor cost in the indirect practice expense allocation for services where the clinical labor costs are greater than the physician work is a mistake. If there is no physician work in a code, then there is no physician work. The clinical labor costs are already accounted for in the direct practice expenses. The proposed method would overvalue the practice expenses for these codes by arbitrarily inflating the indirect costs. We urge CMS to use only physician work for this step in the calculation of indirect practice expenses. The Academy objects to the adoption of "fudge factors" like this to protect the value of classes of codes which might face future cuts.

4.) Use of Discounted Work RVUs in Indirect Practice Expense Calculations:

It appears that CMS has used WRVUs calculated after budget neutrality adjustments. This would lead to inaccurate payments of practice expenses and is just another reason not to apply budget neutrality as a work adjuster. We urge CMS to use correct work RVUs that have not undergone budget neutrality adjustments. We suggest that CMS use current RUC and CMS values to include the results of the third Five Year Review.

5.) Specialty weighting of PCI

The Proposed Notice states that the Secretary has determined that PE RVUs should reflect the resources required to perform a service for a "typical" patient. Therefore, we suggest that the approach of basing the specialty adjusted weight on a weighted average of all specialties providing a service is flawed. Rather, we suggest that the weight should be based on the weight of the specialty or specialties that represent 95 percent of the total utilization of the appropriate CPT code and modifier. Otherwise, the practice expense (PE) related payment is impacted by the practice costs of specialties who do not represent the "typical" patient.

We believe that this adjustment will be particularly important for codes that are billed by a wide range of specialties that typically are not performing the entirety of the service. For example, CPT code 66894 which describes cataract surgery is billed by 19 specialties, even though almost all of the

procedures are performed by ophthalmologists. Similarly, CPT codes 92012 and 92014, which describe eye exams for an established patient, are billed by 29 and 31 specialties respectively, although ophthalmologists and optometrists account for more than 99 percent of the utilization.

The specialty-based weights impact the PE RVU calculation because the indirect costs are determined based on the direct cost estimate at the procedure level and the ratio of direct and indirect costs at the practice level. AAO has analyzed the proposed PE RVUs and determined that an alternative approach described below would correct some of the anomalies that result from the inclusion of specialties that are not typically related to a procedure code. In addition, we believe that the utilization data used in calculating the weighted values for CPT 66984 are incorrect and do not reflect the clinical reality and the roles of ophthalmologists and optometrists in the service.

The utilization data contained on the CMS website indicates that 85.4 percent of the utilization of CPT 66984 is associated with an ophthalmologist while another 14.2 percent is associated with an optometrist and 0.4 percent is associated with some 17 other specialties. This belies the clinical reality that the surgery is exclusively provided by ophthalmologists. Optometrists are involved only during the post-procedure period for a number of post-operative visits and not involved in the preservice, intraservice, and day of service discharge portions of the procedure. The clinical reality could be confirmed if the utilization data at the CPT code level also included modifiers since most optometrists will bill for CPT code 66984 with the "-54" modifier to indicate the care associated with the post- operative period. The published PE RVU appears to reflect the 0.854 and 0.142 for ophthalmology and optometry, respectively with an additional small weight used to distribute the 0.4 percent associated with the other 17 specialties.

AAO suggests that the PE RVU for CPT 66984 be based solely on ophthalmology utilization, or if a weighting of the optometry practice costs is necessary, that the weight assigned reflect either the clinical reality of the service provided by optometry affect only the postoperative portion of the service. The result will be a PE RVU which better approximates the resources needed to perform this service.

6.) Summary

In general, the Academy is very disappointed with the currently proposed hybrid practice expense methodology incorporating both bottom up and top down principles. Our understanding, after attending the CMS sponsored February "Town Hall" in Baltimore, was that the new practice expense methodology was going to adopt a bottom up methodology and was to be more transparent by utilizing the comprehensive and complete data on direct practice expenses developed by the RUC PEAC and PERC committees working with CMS staff. While a significant improvement over the 2005 proposed rule, the proposed methodology for practice expenses is still confusing, lacks transparency, manipulates policy to reward some services

with little or no physician work, distorts the Medicare physician fee schedule and is frankly poor public policy.

The Academy appreciates your consideration of these comments. We would be glad to provide any additional supporting documents that you require and would be pleased to meet with you to discuss any of these issues in greater detail.

Sincerely,

Michael X. Repka, MD

Submitter : Dr. John Lyman **Date:** 08/21/2006

Organization : Emergency Department Practice Management Assoc.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2270-Attach-1.PDF

#2270

Emergency Department EDPMA Practice Management Association

8405 Greensboro Drive, Suite 800
McLean, VA 22102
Phone: (703) 506-3292
Fax: (703) 506-3266

August 21, 2006

By Electronic Submission

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

RE: CMS-1512-PN: Medicare Program; Five-Year Review of Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology, 71 Fed. Reg. 37,170 (June 29, 2006).

Dear Administrator McClellan:

We write today to submit formal comments to the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the Five-Year Review of Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology, 71 Fed. Reg. 37,170 June 29, 2006.

The Emergency Department Practice Management Association (EDPMA) is the organization that advocates for emergency physician groups and their partners to enhance quality patient care through operational excellence and financial stability. EDPMA members include emergency department medical groups, emergency department billing companies, and business partners who support emergency department medical groups. EDPMA members represent approximately one-third of all of the emergency department visits in the U.S. through direct patient care or support services to physicians and providers.

EDPMA Supports Proposed RVUs for Emergency Medicine

EDPMA is supportive of both the RUC recommendations and CMS' proposed rule with regard to work relative value units (RVUs) for Evaluation and Management (E/M) services. In particular, we strongly support CMS' acceptance of the RUC's recommendations for emergency department visits (CPT codes 99281-99285) and for critical care services (CPT codes 99291-99295), which represent many of the important services provided in the emergency department. We urge CMS to make no changes in the final rule that would place in jeopardy these important proposed changes for emergency medicine and our patients.

Budget Neutrality Should Apply to the Conversion Factor and Not to Work Values

CMS proposes to adopt physician work RVUs that would increase Medicare expenditures for physicians' services by $4 billion. However, CMS noted that the statute requires CMS to implement RVU adjustments on a budget neutral basis. As a result, CMS adopted many of the recommended RVUs from the RUC and then reduced all work RVUs by approximately 10 percent to attain budget neutrality.

EDPMA disagrees with the approach that CMS has proposed to attain budget neutrality. Specifically, we believe thatC MS should continue its long standing policy of applying the budget neutrality adjustments to the conversion factor and not to the RVUs. If the RVUs are reduced to accommodate budget neutrality, the improvements to valuation of E/M services will be reduced as well and the full benefit of these improvements will not be achieved.

CMS payment policy also has a ripple effect on the policies of other payors. Many private and public payors tie their payment structure to the Medicare RVUs. Applying budget neutrality adjustments to the conversion factor and not to the work RVUs is less likely to seriously adversely affect physician payments from other payors in the market.

CMS' Methodology Provides Inadequate Practice Expenses for Emergency Medicine

Direct Costs Should be Calculated Using Actual and Full RVUs

CMS proposes to use physician work RVUs negatively adjusted for budget neutrality as the basis for allocation of direct costs. This methodology is inappropriate as CMS acknowledges through their adoption of many of the RUC's recommendations that the RVUs are accurate and will be reduced in practice only by the statutory constraint imposed by budget neutrality. The actual and full RVUs should be used to allocate indirect costs regardless of the final outcome on budget neutrality discussed above.

Supplemental Surveys and IPCI Result in Inequities in Reimbursement Across Specialties

EDPMA is concerned that specialty societies that have resources to develop and submit to CMS their own supplemental survey data have realized significant increases in practice expenses while other smaller and less financed specialties, including emergency medicine, which have been unable to do so, continue to see lower levels of reimbursement for practice expenses.

In addition to lacking a supplemental survey, emergency medicine has been disadvantaged because the emergency physician group practice models do not adequately conform to the American Medical Association's SMS historical database which is populated by office-based physicians and upon which CMS relies. In addition, emergency physicians, represented by the American College of Emergency Physicians (ACEP) have been unable to meet sampling criteria for external survey submission, the result of which has been the continuation of practice expense payment inequities. EDPMA supports the comments submitted pursuant to the proposed rule by

ACEP regarding the difficulties associated with CMS' policy permitting specialty supplemental surveys and the call for a new multi-specialty survey.

The payment disparities resulting from CMS' allowance of supplemental surveys is amplified by CMS' changes to the methodology regarding the Indirect Practice Cost Index (IPCI). This is evidenced by the ICPI listed in the proposed rule which places at the very top numerous specialties that have submitted supplemental survey data including: Cardiology, Dermatology, Gastroenterology, Dermatology, and Hematology/Oncology. Conversely, at the bottom of the IPCI index and with IPCIs of less than 1.00 are critical health care services used by every American including: General Practice, Family Practice, Internal Medicine, Pediatric Medicine, and Emergency Medicine, which has an extremely low IPCI of 0.500 and has not been able to provide a supplemental survey. The IPCI for emergency medicine is based on survey data that is inconsistent with actual practice costs and CMS' use of the ICPI will reduce indirect costs for services provided predominantly by emergency medicine by 50 percent. We strongly object to this inappropriate reduction and we urge CMS to eliminate the use of the IPCI in the final rule.

CMS should not utilize supplemental survey data from specialty societies until a new multi-specialty survey has been completed in order to eliminate inequities among the specialties. To this end, EDPMA calls upon CMS to move forward with a new multi-specialty survey that is well designed to ensure the reporting of common data elements in a timely and equitable manner. This survey must properly accommodate emergency physician groups, allow for data collection at the practice level, and include the expenses associated with the provision of uncompensated care.

Uncompensated Care is a Legitimate and Significant Practice Expense for Emergency Medicine

The burden of providing uncompensated care to individuals in need falls disproportionately on emergency physicians who are required under federal law to provide emergency services regardless of the patient's ability to pay. The costs of providing uncompensated care are a necessary and legitimate practice expense for emergency medicine. CMS' recognition of this fact is long overdue.

While the problem of providing uncompensated care to many patients should not fall on Medicare alone, these costs are directly related to physician participation in the Medicare program. As such, physicians should receive adequate compensation for incurring such costs. To this end, the independent Institute of Medicine (IOM) in a recent report on emergency medicine wrote:

> The evidence suggests that the burden of providing uncompensated services is placing communities at risk by failing to ensure the continued financial viability of a critical public safety asset-- the 24 hour availability of critical life-saving emergency and trauma services. Consequently, the committee believes that the emergency care system requires a special funding source, separate from the regular DSH formula, to adequately compensate hospitals and physicians for the burden of providing services to uninsured and

> underinsured populations. To ensure the continued viability of a critical public safety function, the committee recommends that Congress establish dedicated funding, separate from DSH payments, to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care for the financial losses incurred by providing those services. *Hospital-Based Emergency Care: At the Breaking Point*,I nstitute of Medicine, June 14, 2006, page 45, Emphasis in original removed.

While we understand that CMS cannot alone make the changes suggested by the IOM, CMS could take significant steps to alleviate the tremendous burden on emergency departments by including uncompensated care in the calculation of specialty practice expense.

We appreciate the opportunity to provide formal comments to CMS' proposed Medicare regulations. Please feel free to contact me or EDPMA's Managing Director, Cherilyn Cepriano, at (703) 506-3292 regarding these comments or any other issues facing emergency medicine.

Sincerely,

John Lyman, MD, FACEP
Chairman
Emergency Department Practice Management Association