Submitter : **Dr. Timothy Parker** **Date: 11/29/2004**

Organization : **ADS Ambulatory Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Please see comments in the proposed deletions above.

I am a skin cancer surgeon and these codes (114xx,116xx,131xx,140xx, and 157xx) are ones that we use daily. Deleting these would severly impact the care delivered by dermatologic surgeons, plastic surgeons, otolaryngologists, and other reconstructive surgeons. Many of these surgeons will lean more toward cosmetic procedures and away from serving Medicare patients with skin cancer if these deletions persist. Many of these doctors will leave Medicare altogether since care for skin cancer patients will be compromised and cosmetic patients will be more appealing to treat. Waiting times for appointments for deadly cancers such as melanoma and squamous cell carcinoma will dramatically increase from several weeks (which is already too long) to several months to be seen. More Medicare patients will die prematurely and suffer from complications from office surgery.

These codes should not be deleted from the ambulatory surgery center list. I ask that you reconsider this action to prevent a mistake!

Issues

Proposed Deletions from the list of ASC covered procedures.

114xx, 116xx, 131xx, 140xx, and 157xx codes should not be deleted for many reasons.

1) I used to do these procedures in my office but do them now in a surgery center because of the reduced complications (infections),better monitoring of patients with pulse oximetry and blood pressure devices, and better ability to handle emergent situations that arise during these procedures (cardiopulmonary arrest, stroke, anesthetic reaction, allergic reaction, diabetic reactions). Most of these patients are elderly with multiple medical problems that need emergent care best administered or only administered in an ambulatory surgery center.

2) State legislation in most states (including Kansas) either is or soon will be enacted forcing these procedures and others to be done in ambulatory surgery centers instead of doctors offices because of public outcry over the unsafe conditions resulting in medical errors and disasters nationwide. Medicare would place doctors and patients in a no win situation resulting in dangerous care if these surgical procedures are forced back into the office setting.

3) Many patients requiring these reconstruction codes are on blood thinners (coumadin, aspirin, Plavix) and immunosuppressants that lead to more frequent emergent care only properly done in a ambulatory surgery center with ACLS training and comprehensive regulation compliance.

4) Most of these patients require the expertise and training of registered nurses to care for them in an ambulatory surgery setting that they do not get in an office setting with medical assistants and certified nursing assistants.

5) The care I deliver now compared to the past when I did these procedures in my office is dramatically better, more thorough, and much safer thanks to the stringent regulations and procedures developed and followed in an ambulatory surgery center.

Submitter : **Dr. Jules Geltzeiler** **Date: 12/01/2004**

Organization : **Dr. Jules Geltzeiler**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a Urologist I am concerned about the deletions of the above codes from the ASC covered procedures list. It is expected that close to 230,ooo new cases of prostate cancer will be diagnosed this year. An estimated 750,000 to 1 million men will have a prostate biopsy performed (code 52000). As reported in the Prostate Cancer Foundation's Report to the Nation it is now the standard of care that any where from 10 to 30 biopsies be done during this procedure. This standard use to be 6. This procedure in general is very uncomfortable to painfull. It is uniformly done in conjunction with a transrectal prostate ultrasound wihich requires a 1 inch wide solid tube to be inserted 3 inches up your rectum, after which the 1/16 inch wide biopsy needles in thrust into the prostate thru the rectal wall to obtain a single sample. To deprive men of the option of having IV sedation and a painless procedure is cruel to the patient and may act as a deterrrent from them having an important diagnostic procedure.

Cystoscopy, code 52000, is used to diagnosis many different urologic diseases. Imagine having a 1/2 inch wide steel tube or a 1/4 inch wide flexiable tube shoved in your through your penile urethra to exam your bladder. Your asking our patients to do this without the option of having a painless procedure with IV sedation. Again cruel.
If a area of scarring in the urethra is noted and needs to be dilated (code 52281), you are again saying, "you can take the pain".

I have done all these procedures both using local anesthesia and under IV sedation in an ASC setting. There is no question that the patients are much more comfortable, less anxious, and have less complications when these procedures are done under IV sedation.

Imagine if you needed these procedures done. My response can be, sure we can do this here in the office and it will hurt or you can have it done painlessly at an ASC. If you have Medicare though this is not covered at an ASC, so from an economic perspetive you should have it in the office. Do not worry, you will be able to take the pain. I implore you not to remove these codes from the ACS covered list of procedures.

Thank you.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000, 52281, 55700

Submitter : **Dr. sam litvin** **Date: 12/02/2004**

Organization : **Dr. sam litvin**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

As a Urologist I am concerned about the deletions of the above codes from the ASC covered procedures list. It is expected that close to 230,ooo new cases of prostate cancer will be diagnosed this year. An estimated 750,000 to 1 million men will have a prostate biopsy performed (code 52000). As reported in the Prostate Cancer Foundation's Report to the Nation it is now the standard of care that any where from 10 to 30 biopsies be done during this procedure. This standard use to be 6. This procedure in general is very uncomfortable to painfull. It is uniformly done in conjunction with a transrectal prostate ultrasound wihich requires a 1 inch wide solid tube to be inserted 3 inches up your rectum, after which the 1/16 inch wide biopsy needles in thrust into the prostate thru the rectal wall to obtain a single sample. To deprive men of the option of having IV sedation and a painless procedure is cruel to the patient and may act as a deterrrent from them having an important diagnostic procedure.

Cystoscopy, code 52000, is used to diagnosis many different urologic diseases. Imagine having a 1/2 inch wide steel tube or a 1/4 inch wide flexiable tube shoved in your through your penile urethra to exam your bladder. Your asking our patients to do this without the option of having a painless procedure with IV sedation. Again cruel.
If a area of scarring in the urethra is noted and needs to be dilated (code 52281), you are again saying, "you can take the pain".

I have done all these procedures both using local anesthesia and under IV sedation in an ASC setting. There is no question that the patients are much more comfortable, less anxious, and have less complications when these procedures are done under IV sedation.

Imagine if you needed these procedures done. My response can be, sure we can do this here in the office and it will hurt or you can have it done painlessly at an ASC. If you have Medicare though this is not covered at an ASC, so from an economic perspetive you should have it in the office. Do not worry, you will be able to take the pain. I implore you not to remove these codes from the ACS covered list of procedures.

Submitter : **Marcy Kincaid** **Date: 12/07/2004**

Organization : **Central Ohio Surgical Institute**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

"Please see attachment"

CMS-1478-P-4-Attach-1.TXT

Submitter : **Dr. Joseph Leoni** **Date: 12/07/2004**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on the proposed deletion of CPT codes 52000, 52281 and 55700.

CMS-1478-P-5-Attach-1.DOC

CMS-1478-P-5-Attach-1.DOC

Submitter : **Dr. John M. Henry** **Date: 12/08/2004**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on the proposed deletion of CPT codes 52000, 52281 and 55700.

CMS-1478-P-6-Attach-1.DOC

CMS-1478-P-6-Attach-1.DOC

Submitter : **Dr. Michael Schoo** **Date: 12/09/2004**

Organization : **Dr. Michael Schoo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS,
I am an orthopedic surgeon with 25 years experience practicing in a rural western state setting and am writing to request that CMS reconsider some of its deletions to the list of procedures approved for an ASC. I have reviewed the list of deletions and certainly agree with some, others appear inappropriate and counterproductive. I agree there are not many calcaneal fractures which should be internally fixed in an outpatient setting and that probably any ankle fracture severe enough to require surgery is not likely to be appropriately done in an outpatient setting. However, delayed primary closure of wounds, minor full and partial thickness skin grafts of the forearm and hand, percutaneous fixation of humeral neck fractures and humeral epicondyle avulsions, internal fixation of simple olecranon fractures, internal fixation of metacarpal fractures, and percutaneous or external fixation of radius fractures are all ideal procedures for an ASC setting and should not by regulation be forced into a higher overhead inpatient setting. Thank you.

Respectfully,
Michael J. Schoo, M.D.

Submitter : **Dr. Alan N. Fleischer** **Date: 12/09/2004**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on the proposed deletion of CPT codes 52000, 52281 and 55700.

CMS-1478-P-8-Attach-1.DOC

CMS-1478-P-8-Attach-1.DOC

Submitter : **Dr. Peter Pritchett** **Date: 12/10/2004**

Organization : **Black Canyon Surgical Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

Laser procedures 67145, 65855, 6721067208,67220,and 67228 should be added to ASC covered procedures. As a rural provider, we need access to a laser, but cannot afford to buy one for the office given the minimal reimbursement offered by CMS for these procedures.

Proposed Deletions from the list of ASC covered procedures.

see attachment

CMS-1478-P-9-Attach-1.DOC

CMS-1478-P-9-Attach-1.DOC

Submitter : **Dr. Stephen Lee** **Date: 12/11/2004**

Organization : **Urology Associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

52000, 52281, 55700
The above CPT codes should REMAIN on the ASC list for covered procedures. There are certain patients who cannot tolerate cystoscopy, dilation, or prostate bx in the office. Urethral dilation can be especially painful. I welcome you to have this in the office. Cystoscopy in a younger pt may not be tolerated, esp children. Consider your child having that procedure in the office. Lastly, a pt may have an anal stricture due to prior hemorrhoid surgery and will not accomodate the transrectal ultrasound for a prostate biopsy. Thus, the pt may require incision or dilation of the stricture PRIOR to the prostate bx. Again, if it were you, I do not think you would want this done in the office setting.

PLEASE reconsider keeping these ON the covered ASC procedure list.

Submitter : **Dr. Jeffrey Kaufman** **Date: 12/11/2004**

Organization : **California Urologic Association**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

The proposal to delete these 3 codes from the ASC covered procedure list will cause harm to patients, deny care and increase costs to the Medicare program. Under certain conditions that must be left to the judgement of the physician and patient, these 3 procedures can be painful to the point of requiring sedation or anesthesia beyond what is available in a doctor's office. Under those circumstances, attempting to proceed in the office with inadequate sedation is cruel and dangerous. Under current regulations, these are often performed efficiently and in a cost effective manner in an ASC. If these codes are removed from the list, they will be done instead in the hospital operating room rather than in the office at a substantial increased cost to Medicare. Cystoscopy alone can be too painful to perform awake--especially when bleeding, a stone or a tumor is present and further manipulation is necessary (this would cause duplicative services if done once in the office and again under sedation at the hospital if not done once only under sedation in the ASC). When combined with dilation to stretch a stricture, the procedure can be far too painful for office sedation and risky when done awake in the elderly male patient. Further, current practice now requires that 12-20 cores be taken with any prostate biopsy. This is far beyond the ability of office local anesthesia to control. Costs are greater in a hospital operating room and performance is much less efficient causing losses for both Medicare and patients when an ASC facility is denied. Moreover, for each of these 3 procedures, sterility in an ASC may be better than in the office. Closing off the use of an ASC would not force these patients back into an office setting; it would send them into a more expensive hospital location. To avoid duplicative services, to keep costs under control, to allow appropriate levels of sedation to be used and for health and safety reasons, the codes for cystoscopy (52000), cystoscopy with dilation (52281) and prostate biopsy (55700) should be kept on the ASC covered procedure list. The OIG has used faulty out of date data and based their recommendation on faulty assumptions in making their recommendation to have these codes removed. Please help us help our patients and keep costs down by maintaining them on the list.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000
52281
55700

Submitter : **Dr. Robert Donato** **Date: 12/11/2004**

Organization : **Urology Center of the South**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Comment

Issues

Proposed Additions to the list of ASC covered procedures.

Since advancing age is often accompanied by the development of urinary incontinence, it seems appropriate to make use of the technologies available that require minimal operative anesthetic risk and (to date) the most durable cure. As such, addition of the sling to the ASC Medicare list is a step in the right direction. The reimbursement level should be commensurate with the current cost of disposables for the facility; thus, level 9 coding appears more in line with estimates for expenses involved in providing this service.

Proposed Deletions from the list of ASC covered procedures.

The proposed deletions from the Medicare ASC procedure list that effect urology should be reconsidered. Cystoscopy, a vital part in the evaluation for and subsequent surveillance of cancer in patients, can be an anxiety provoking procedure. The sedation that may be required can be best administered in the setting where aftercare is performed by dedicated nursing, not by a clinic nurse with multiple responsibilities. Additionally, some patients may require additional treatments (fulguration of tumor, dilation, stone manipulation) at the time of cystoscopy. Is it more cost effective to perform a diagnostic test to only have to repeat it during a therapeutic intervention later? No. While some patients are capable of undergoing such procedures in the office, the risk would be greater. The trend would, thusly, move to have these 'possible' services booked in a hospital setting, where costs to Medicare are greater and efficiency of care is lower. Therefore, CMS should retain these procedures on the ACS list.

Submitter : **Dr. evangelos geraniotis** **Date: 12/11/2004**

Organization : **urology associates of cape cod**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I am writing to oppose the propsed deletion of CPT Codes 5200 52281, and 55700 in ASC settings. Although these may be common procedures often done by Urologists in an office setting, they also quite commonly can be difficult, painful, and time consuming and need to be done in a specialized facility outside of an office setting. A patient may have to be sedated (which we cannot do in the office) or, we may find a problem on cystoscopy that requires treatment that often cannot be done in the office because of the requiremnt of specialized equipment. By doing these procedures in an ASC setting, we have access to the sedation, to the specialized equipment, and to the better trained individuals to help us with our work. If these procedures are shifted away from an ASC, they will require being done in a hospital setting which will be a much more expensive one.
I would therefore strongly urge that these codes remain as is on the ASC list.

Submitter : Dr. **Date:** 12/11/2004

Organization : Dr.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

n/a

Issues

Proposed Additions to the list of ASC covered procedures.

Patient Health and Medical Conditions: CMS should not delete CPT codes 52000, 52281 and 55700 from the Medicare ASC list of covered services. These procedures are performed in a physician's office the majority of the time. However, for Medicare patients who do receive these services in an ASC, it is because the patient's health or medical condition demands the more extensive services and advanced capabilities afforded by ASCs to ensure a safe outcome. Also, all of these procedures are performed more often in a hospital outpatient department than in an ASC, which further supports the case that it is not suitable for certain patients (such as patients with many co-morbidities) to undergo these procedures in an office.
Appropriate Site-of-Service: Physicians - in concert with their patients - should determine the appropriate site to perform a procedure based on clinical indications. Using numeric site-of-service thresholds as the principal determinant for deleting procedures from the ASC list is arbitrary and does not permit cost-effective, individual consideration of a patient's medical needs. In fact, CMS proposed to discontinue using numeric site-of-service thresholds for deleting procedures from the list in its June, 1998 proposed rule, saying that site-of-service is only one of several factors to be taken into account in determining whether or not a procedure should be on the ASC list.
Sterility Issues: The level of sterility in the ASC is identical to that in the hospital. Endoscopes are sterilized in the same device used in the hospital, and iatrogenic infection rates are lower in the ASC.
Option to Provide Proper Care in the Proper Setting: A physician currently has the option of performing CPT codes 52000, 52281 and 55700 in an ASC for patients who require special care. If these codes are taken off the ASC list, a physician would be forced to choose the hospital outpatient setting for patients requiring special care that can not be provided in an office setting. This could:
create higher costs for the Medicare program;
cause inconvenience and higher costs for beneficiaries; and
increase practice expense for the physician as he/she will now have to travel to the hospital to do these procedures which is a very inefficient use of time.
Health and Safety Reasons: CMS medical advisors determined that for health and safety reasons, CPT codes 51710 - change of bladder tube; 51726 - complex cystometrogram; 51772 - urethra pressure profile; 52285 - cystoscopy and treatment should not be deleted from the ASC list as the OIG recommended. Therefore we must convince these same CMS advisors that CPT codes 52000, 52281 and 55700 should also be retained on the list for health and safety reasons, such as:
CPT code 52000, cystoscopy, may be a complex, painful procedure that requires the more advanced, and sterile, capabilities of an ASC.
Sedation Issues: Many offices are not set up to provide the sedation and post-sedation monitoring that is often required for cystoscopy. Not only is it forbidden to administer such intravenous sedation in an office by many medical liability policies, it can be inherently unsafe if the office is not properly equipped. Also, some states have laws and/or regulations that preclude certain levels of sedation in a physician's office, and many others highly regulate such activities.
Additional Procedures: It is not uncommon to do diagnostic cystoscopy only to find significant pathology that requires therapeutic intervention such as biopsy, resection, dilation, fulguration of bleeding points, small bladder tumors or other invasive treatment. Also, cystoscopy to look for bleeding often finds large blood clots and office evacuations are extremely painful. In many cases that intervention can be addressed at the time of cystoscopy.

Proposed Deletions from the list of ASC covered procedures.

n/a

Submitter : Dr. **Date:** 12/11/2004

Organization : Dr.

Category : Physician

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

CPT code 52281 (Cystoscopy with urethral dilation): Dilation of a stricture that requires cystoscopic guidance is a painful and complex procedure requiring specialized equipment, dilators, personnel, as well as sedation and often general anesthesia.
CPT code 55700 (Prostate Needle Biopsy): Ultrasonic Guided Prostate Biopsy, usually done in association with transrectal ultrasound, now routinely includes 12-20 separate biopsies. It is uncomfortable and sometimes includes intravenous sedation. It is unreasonable in today's medical legal climate to expect Urologists to administer intravenous sedation without appropriate safeguards sometimes available only in an ASC or Hospital setting.
Duplication of Services: The deletion of CPT code 52000 (cystoscopy) from the ASC list will be counterproductive by effectively requiring duplication of a similar but more complex service in an ASC after the diagnostic service is done in the office. In an era when efficiency and cost effectiveness is the goal, this deletion is counterproductive and represents a threat to patient health and safety.
CMS Data is Out of Date: CMS proposes to delete CPT codes 52000, 52281 and 55700 based on the January 2003 OIG study of ASC and outpatient payments. However, the OIG study is based on outdated data and is therefore not currently a reliable indicator of cost savings in the Medicare program.
Faulty CMS Assumptions: CMS should not assume that deleting these codes from the ASC list will save money based on the rationale that the procedures currently done in an ASC will migrate to the less expensive office setting.
Efficiency and Safety: The ASC is highly efficient, providing a safe and efficient alternative to the hospital. The additional time burden of transferring these ASC cases to the hospital will effectively reduce availability to care for other patients and ultimately create an access problem. Time and efficiency are one effective tool physicians have to deal with the challenges in our current health care environment. Deleting these codes from the list will take this tool away from physicians.

Submitter : **Dr. TIMOTHY DUFFIN** **Date: 12/11/2004**

Organization : **SOLO PRACTICE**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I WOULD RECCOMEND ANYONE WANTING TO CHANGE THESE, HAVE THE PROCEDURE IN THE ASC, HOSPITAL AND THE OFFICE. IT WOULD BE A NO BRAINER, AFTER COMPARING THE THREE CHOICES.

THANK YOU.

TIM DUFFIN, MD UROLOGIST, CLARKSVILLE, TN

Issues

Proposed Additions to the list of ASC covered procedures.

I WOULD RECCCOMEND NOT DELETING CYSTOSCOPY, URETHRAL DILATATION AND OTHER PROPOSED GU CHANGES. THE PATIENT'S ARE MORE COMFORTABLE, IT IS SAFER AND PROVIDES A BETTER QUALITY OF CARE. I ASK IF ANYONE MAKING THIS DECISION, HAD ANY OF THESE PROCEDURES IN THE OFFICE? THEY HURT!!! ALOT!!!
PERFORMING THESE IN A HOSPITAL SETTING IS WORSE,SINCE THEY ONLY TAKE ABOUT 10MINUTES TO DO, ONLY A LITTLE SEDATION IS NEEDED. THE SURGERY CENTERS SPECIALIZE AND PERFORM BETTER ON THIS "MINOR CASES" THAN MIXING THESE SMALL CASES IN WITH LARGER ONES. ALSO, OR TIME IN THE HOSPITAL'S ARE LIMITED, AND THIS WOULD ONLY MAKE IT MORE CROWDED.
I WOULD ALSO RECCOMEND TAKING CARE OF STONES, ON MEDICARE PATIENTS IN THE ASC SETTING. 50590, 52353, ETC AREA MUCH BETTER WHEN DONE, IN AN ASC, AGAIN LEAVING ROOM IN THE HOSPITAL FOR OUR BIGGER CASES

Submitter : **Dr. Boris Klopukh** **Date: 12/11/2004**

Organization : **Dr. Boris Klopukh**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This would be a travesty for the patient. Some patients need to be done at the ambulatory setting because they are unable to tolerate the procedure unless somee form of anesthesia or sedation is used.

Think of it this way. If you needed a procedure done like a biopsy (55700) of the prostate but were unable to tolerate the pain, should i subject you to painful cruelty or give you an option for sedation in an ambulatory setting. This is a no brainer, you would choose sedation/anesthesia. Same applies for cystoscopy (52000, 52281). Dont be cruel by changing the rules and deleting the above codes - think of the consequences.

Issues

Proposed Deletions from the list of ASC covered procedures.

On November 19, the Centers for Medicare & Medicaid Services (CMS) released a proposal to update the Medicare ambulatory surgical center (ASC) list of covered procedures effective July 1, 2005. The rule includes some items of note for urology, particularly the proposal to delete CPT codes 52000, 52281 and 55700 from the ASC list.

Submitter : **Dr. JERROLD SHARKEY** **Date: 12/11/2004**

Organization : **UROLOGY HEALTH CENTER**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

"SEE ATTACHMENT"

Issues

Proposed Deletions from the list of ASC covered procedures.

CPT codes 52000, 52281 and 55700

CMS-1478-P-18-Attach-1.DOC

CMS-1478-P-18-Attach-1.DOC

Submitter : **Dr. JOHN ANDENORO** **Date: 12/12/2004**

Organization : **UROLOGY ASSOCIATES**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

I have just learned that the three above CPT codes have been targeted for deletion. That is such bad decision making it borders on incompetence. While most of these procedures can and should be done in a clinic setting, occassionally patient safety and comfort demand that they be performed in a monitored and assisted setting such as an ASC or hospital. Many physicians don't have the staff to safely move and care for a severely disabled patient in order to perform an in office cysto. Imagine trying to move a 250lb wheel chair bound invalid who has undergone bilateral lower extremity amputations in a clinic with just a physician and a medical assistant. Do I need to give you more examples, or can you see the folly of your proposal. The idea of denying patients access to ASC's for urethral dilations is even more foolhardy! Though many of these procedures can be safely and appropriately done in a clinic setting, denying access to care in an ASC might mean delaying care, not having adequate staff or instruments available, or not being able to provide a patient necessary analgesia (or anestheisa, if required). As for 55700, what about the patient who has no anus? In our community only the ASC is appropriately equipped to provide adequate means to conduct a perineal ultrasound guided biopsy for patients who have undergone abdominoperineal resection. Would you just like to deny them the ability to identify and treat prosate cancer? Suggesting that these three codes be removed from ASC lists shows a profound lack of insight or concern for the subtlties and complexities of good patient care in most US communities.

Issues

Proposed Deletions from the list of ASC covered procedures.

5200, 52281, 55700

Submitter : **Dr. Mark Uhlman** **Date: 12/13/2004**

Organization : **Dr. Mark Uhlman**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I am writing to comment against the deletion of codes 52000 (Cystoscopy) 55700 (Prostatic needle Biopsy) and 52281 (Cystoscopy with urethral dilation) from the list of approved Ambulatory Surgery Center procedures.

While cost containment is a laudable goal, the deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to Patient health and safety. Each of these codes represents a procedure that while often performed in an office setting clearly need the advanced setting provided by an ASC in a significant percentage of cases. To administratively remove a cost and time effective alternative to the hospital to do these procedures is a violation of our fiduciary responsibility to our Medicare Patients

?The American people deserve a regulatory system that works for them, not against them: a regulatory system that protects and improves their health, safety, environment, and well-being and improves the performance of the economy without imposing unacceptable or unreasonable costs on society; regulatory policies that recognize that the private sector and private markets are the best engine for economic growth; regulatory approaches that respect the role of State, local, and tribal governments; and regulations that are effective, consistent, sensible, and understandable.?

These words, the preamble to executive order 12866, are the mandate by which you are to evaluate and review the Ambulatory Surgery Center procedure list. The elimination of ASC codes 52000 (cystoscopy), 52281 (Cytoscopy with urethral dilation), and 55700 (prostate biopsy) violates the spirit of this directive and will threaten the health and safety of Medicare Patients who deserve access to reasonable and cost effective Medical services. I urge you to reconsider your decision and keep codes 52000 (cystoscopy), 52281 (cystoscopy with urethral dilation), and 55700 (prostate biopsy) on the Ambulatory Surgery Center Procedure list.

Submitter : **Dr. Mark Uhlman** **Date: 12/13/2004**

Organization : **Dr. Mark Uhlman**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I am writing to comment against the deletion of codes 52000 (Cystoscopy) 55700 (Prostatic needle Biopsy) and 52281 (Cystoscopy with urethral dilation) from the list of approved Ambulatory Surgery Center procedures. While cost containment is a laudable goal, the deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to Patient health and safety. Let me explain:

52000 (Cystoscopy): Cystoscopy is an often complex, painful procedure that, while often performed in a physician?s office, frequently requires the more advanced capabilities of an ASC. It is beyond the expertise of an office setting to provide the oft required sedation and post sedation monitoring for cystoscopy. Not only is it forbidden to administer such intravenous sedation in an office by many Medical Liability Policies, it is inherently unsafe.
It is not uncommon to do diagnostic cystoscopy only to find significant pathology that requires therapeutic intervention such as biopsy, resection, dilation, or other invasive treatment. In many cases that intervention can be addressed at the time of cystoscopy. The deletion of 52000 (cystoscopy) from the ASC list will be counterproductive by effectively requiring duplication of a similar but more complex service in an ASC after the diagnostic service is done in the office. In an era when efficiency and cost effectiveness is the goal, this deletion of 52000 (cystoscopy) is counterproductive and represents a threat to patient health and safety.

52281 (Cystoscopy with urethral dilation): Dilation of a stricture that requires cystoscopic guidance is a VERY painful and often VERY complex procedure requiring specialized equipment, dilators, personnel, as well as sedation and often full anesthesia. It does not necessarily require the hospital setting but does require the ASC setting in a large number of cases. It would be highly inappropriate to remove this code from the ASC approved list. It is simply not a procedure that can be done in an office setting routinely. Removing this option for management of urethral strictures would be a great disservice to patients and Urologist alike.

55700 (Prostatic needle Biopsy): Prostatic Biopsy, usually done in association with Transrectal ultrasound, now routinely includes 12-20 separate biopsies. It is uncomfortable and often includes intravenous sedation. It is unreasonable in today?s medical legal climate to expect Urologists to administer intravenous sedation without appropriate safeguards available only in an ASC or Hospital setting. Again, withdrawing this option is a disservice to Patients and Physician alike.

In conclusion, the decision to delete codes 52000, 52281, and 55700 is not supported by any Urologic organization and opposed by the American Urological Association, the Western Section AUA, the Washington Urological Association, the AACU, the ASUS, and nearly every colleague I speak with. Removing these codes is counterproductive and removes options for efficient and cost effective humane management of many medical conditions. I urge you to reconsider and reinstitute 52000, 52281, and 55700 as ASC approved procedures.

Submitter : Dr. Mark Uhlman **Date:** 12/13/2004

Organization : Dr. Mark Uhlman

Category : Ambulatory Surgical Center

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I am writing to comment against the deletion of codes 52000 (Cystoscopy) 55700 (Prostatic needle Biopsy) and 52281 (Cystoscopy with urethral dilation) from the list of approved Ambulatory Surgery Center procedures.

The deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to patient health and safety. Each of these codes represents a procedure that while often performed in an office setting clearly need the advanced setting provided by an ASC in a significant percentage of cases.

I am a private practice Urologist and I practice in an underserved area. I have a high percentage of Medicare age patients and I depend on efficiency in my practice patterns to maintain adequate income to cover my ever increasing overhead in the face of decreasing reimbursement trends. One of the efficiencies I have in my practice is the use of an Ambulatory Surgery Center. The ASC is highly efficient, providing a safe and efficient alternative to the cumbersome slow bureaucracy of the hospital. The additional time burden of transferring these ASC cases to the hospital will effectively reduce my availability to care for other patients and ultimately create an access problem. Time and efficiency are my only tools to fight the trend of reduced reimbursements. To administratively remove a cost and time effective alternative to the hospital to do these procedures is threat not only to the health, safety, and access of my Medicare patients but to the health and safety of my medical practice.

I urge you to reconsider your decision and keep codes 52000 (cystoscopy), 52281 (cystoscopy with urethral dilation), and 55700 (prostate biopsy) on the Ambulatory Surgery Center Procedure list.

Submitter : **Dr. Donald Rhodes** **Date: 12/13/2004**

Organization : **Sansum Medical Foundation Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Regarding the proposed deletion of cystoscopy (5200) and Cystoscopy with urethral dilation (52281) from the ASC covered procedures, I find this to be increasing both the cost and risk of medical care for my patients. ASC's are much safer with to nosocomial infections. The cost in my community is approximately %50 of what our community hospital charges. Furthermore, our ASC is much more efficient in the time it takes to do either of these procedures.

It makes no sense to me to pay more, spend more time, and expose patients to more infections. If you can rationalize these factors, I would be very surprised.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000 cystoscopy
52281 Cystoscopy with urethral dilation

Submitter : **Dr. Ernest Sussman** **Date: 12/14/2004**

Organization : **Desert Urology**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I am absolutely in shock that you would consider deleting codes 52000, 52281, and 55700. While close to 100% of our patients can tolerate these procedures in the office, there are those that clearly can't. They include patients in whom the procedure is just too painful; 2) those with special antibiotic requirements to prevent sub-acute bacterial endocarditis; and 3) those with anatomic variants not allowing successful completion in the office setting. Please put yourself or your loved one in one of these categories and ask yourself what the Urologist is supposed to do if he or she can't complete these procedures in the office setting. Furthermore, it is cheaper to do these in an ambulatory surgical center than most big hospitals. While most of the lay public and your congressional constituents think you are trying to save money, most of us in the medical profession continue to scratch our heads knowing that some of your moves will actually increase costs. This almost parallels your decision to disallow compensation for home health agencies to give IV antibiotics to medicare patients at home requiring them instead to be admitted to a hospital for the same antibiotic at an inflated cost to everybody involved. We're still trying to figure out that horrible business decision. Respectfully, Ernest Sussman, M.D.

Submitter : **Dr. Edward Janosko** **Date: 12/14/2004**

Organization : **Eastern Urological Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs: I am a urologist and have no financial interest in any surgicenters. I do do have a siginificant interest in my patients care. The above procedures at times must be performend with concious sedation or general anethesia eventhough many are performed in the office with local anesthesia. These patients should be allowed to be done in the ASC setting for the safety secondary to their anesthetic. I t is more cost effective to do these procedures in the ASC setting than in the hospital. Sincerely.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000, 52281, 55700

Submitter : **Dr. Geof Bisignani** **Date: 12/15/2004**

Organization : **Dr. Geof Bisignani**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

The ASC is highly efficient at providing safe alternative to the patient with high patient satisfaction. Deleting urology codes 5200, 55700 and 52281 is a mistake. Several patients need sedation and/or IV antibiotics for these procedures and this can not be provided in the office setting. These are good cases for an outpatient center and this change will force the cases to be done at the hospital at a higher cost and less efficient manner and more inconvenient to the patient.

Issues

Proposed Additions to the list of ASC covered procedures.

Extracoporeal Shock wave lithotripsy(ESWL)

Submitter : **Mr. Dale Holmes** **Date: 12/15/2004**

Organization : **Biltmore Surgical and Recovery Care Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Comments Regarding Codes 3575, 35476, 37205 37205

From the Biltmore Surgical and Recovery Care Center
2222 E. Highland Av, Ste 100
Phoenix AZ 85016

www.bilmoresurgerycenter.com

12-14-04

I would like to endorse the fact that according to most nephrologists, these codes belong in an outpatient setting.

At our facility we are licensed by the state for 72 hours of recovery care.

I would encourage Medicare to look other codes that make sense in an outpatient surgical facility that has a recovery care center.

Dale Holmes
CEO
Biltmore Surgical Center

Issues

Proposed Additions to the list of ASC covered procedures.

35475
35476
37205
37206

Submitter : **Dr. Kenneth Woo** **Date: 12/15/2004**

Organization : **Dr. Kenneth Woo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment/letter

CMS-1478-P-28-Attach-1.DOC

Submitter : **Dr. Timothy Pflederer** **Date: 12/16/2004**

Organization : **Renal Intervention Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Section 2A2: 2004 cpt code changes - asking to review group level. Costs of the catheter are $250-350 and therefore an ASC cannot recoup costs at Group 2.

See attachment

Issues

Proposed Additions to the list of ASC covered procedures.

Agree with adding cpt codes 35475, 35476, 37205, 37206.
Need to reimburse the cost of a stent separately as an implantable device.
Need to add 36145, 36120, and 36140 as they are the diagnostic study which may or may not lead to 35475, 35476, 37205, 37206. Without these codes the ASC receives payment only if an angioplasty intervention is found to be required.

CMS-1478-P-29-Attach-1.DOC

CMS-1478-P-29-Attach-1.DOC

Submitter : **Dr. John Kishel** **Date: 12/16/2004**

Organization : **Central Maryland Urology Associates**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-30-Attach-1.DOC

Submitter : **Dr. Gary Linn** **Date: 12/18/2004**

Organization : **Coastal urology associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

52000,52881,55700,
Deleting Cystoscopy and prostate biopsy from ambulatory care facilities would be a major step backward in the quality and safety of urological care for Medicare patients. Any male who has had these procedures in a physicians office without the benefit of sedation/anesthesia will tell you how painful and stressful these procedures are! The standard of care for prostate biopsies is now 14 cores. That means firing the biopsy gun 14 times through the man's rectal wall and into his prostate. Without anesthesia, older men under stess and pain (as do all men) release epinephrine. This causes a rise in BP and heart rate and vasoconstriction. All the above can contribute to MI or Stroke, And therefore to a costly hospital stay. The same is true for cystoscopy. In addition cystoscopy is a major diagnostic procedure. In a Surgicenter setting if pathology such as a stricture or bladder tumor are found, they are addressed at that same sitting. If the cystoscopy were done in the office, and pathology were found, the patient would have to be scheduled for a second procedure at another time, resulting in inconvience for the Medicare patient and total higher costs for Medicare.. In summary please do not delete the above 3 codes and push the care of the Medicare Urological patient back into the Dark Ages and in essence set up a two tiered system of Urologic care in this country -State of the Art for all but the elderly and inferior care for our senior citizens.
Respectfully,
Gary C. Linn MD FACS

Submitter : **Dr. W. Jack Lovern** **Date: 12/20/2004**

Organization : **Dr. W. Jack Lovern**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1478-P PROPOSED DELETIONS

Dear Sirs,

Rather than decreased Medicare expenditures, there will be a steep rise in Medicare costs for a large number of urologic procedures if codes 52000 (cystoscopy), 55700 (Prostate Needle Biopsy) and 52281 (Cystoscopy with Urethral Dilation) are deleted from the list of approved procedures for Ambulatory Surgery Centers. That cost increase will far outweigh any hoped-for savings from their deletion.

Let me explain: Receipts for these three procedures are keeping urology-specific Surgery Centers afloat financially - for receipts for these three procedures are subsidizing the other procedures being performed in Ambulatory Surgery Centers - procedures that must be performed either in an Ambulatory Surgery Center or a Full-Service Hospital. Many urology procedures are now being performed in ASC's at little or no profit margin, and in some cases at a loss. Therefore ASC's cannot continue in business if these three procedures are deleted. Nation-wide, Ambulatory Surgery Centers will be forced to close - then ALL ambulatory urology procedures will be moved to Full-Service Hospitals - and the cost to Medicare will increase dramatically. The decision to delete these three procedures will then be viewed as 'penny-wise and pound-foolish'.

Over the past few years the Office of the Inspector General has clearly documented the dramatic savings realized by Medicare as large numbers of procedures were moved out of Full-Service Hospital settings into Ambulatory Surgery Centers. Despite that documentation, reimbursement to Ambulatory Surgery Centers was recently frozen for the next five years - while Medicare reimbursement to Full-Service Hospitals is being increased. That action has placed Ambulatory Surgery Centers in significant jeopardy - but these proposed deletions will assure their demise.

Admittedly, those urologists without access to an Ambulatory Surgery Center have been performing these three procedures in their offices and, on first glance; requiring this of all urologists might appear more cost-effective. The office setting, however, may be adequate for some Medicare patients, but not for all Medicare patients, - and those Medicare patients needing general anesthesia or intravenous sedation are being taken from such offices to Full-Service Hospitals where the cost is higher. But beyond that, within such offices (without access to an ASC) EVERY Medicare patient needing ANY ambulatory procedure is being taken to a Full-Service Hospital - therefore these urologists without access to an Ambulatory Surgery Center are generating a dramatically higher overall cost to Medicare in comparison to those urologists performing these three procedures within Ambulatory Surgery Centers - along with all the other procedures that will be moved back into Full-Service Hospitals when these deletions force the closure of Ambulatory Surgery Centers.

In summary then, because of the much higher cost of care that will inevitably result, it is essential that you reconsider and keep these three procedures on the list of approved Ambulatory Surgery Center procedures. But beyond that, reverse the earlier decision to freeze Ambulatory Surgery Center facility fees and allow these entities the same rates of increase now being allowed to Full-Service Hospitals. Medicare must not establish policies that force the closure of Ambulatory Surgery Centers.

Respectfully submitted,

W. J. Lovern, MD

Issues

Proposed Deletions from the list of ASC covered procedures.

52000, 52281, 55700

Submitter : **Ms. Jennifer Richmond** **Date: 12/20/2004**

Organization : **Columbia Endoscopy Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

VIA Electronic Submission

Centers for Medicare and Medicaid Services (CMS)
U.S. Dept. of Health and Human Services
Washington, DC

RE: Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures; Proposed rule; 69 Fed. Reg. 69,178 et seq. (November 26, 2004)
CMS-1478-P

Dear Sir or Madam:

Please accept these comments concerning the CMS proposed rule with comment period ending January 25, 2005 regarding additions to and deletions from the list of approved ambulatory surgical procedures (ASC List).

Our ambulatory surgery center (ASC) is located in Columbia, Missouri and has been in operation for 1 year. We are commenting on the proposed changes because our review of these changes indicates that the procedures listed below should remain on the approved listing.

We are requesting that the following codes, which are included in the proposed deletion list, not be deleted. Our concern and reasoning is noted as well.

CPT Code Description Comments
43237 Endoscopic Ultrasound Limited to the Esophagus We feel that this procedure is appropriate for the ambulatory surgery center setting
43238 With Trans Endoscopic Ultrasound-guided intramural or transmural fine needle aspiration/biopsies esophagus (includes endoscopic ultrasound examination limited to the esophagus) We feel this procedure is appropriate for the ambulatory surgery center setting.
43257 With delivery of therml energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease. We feel this procedure is appropriate for the ambulatory surgery center setting.
45330 Sigmoidoscopy, flexible, diagnostic, with or without colletion of specimens by brushing or washing We feel this procedure is appropriate for the ambulatory surgery center setting.

Thank you for your time and consideration of our request. If you should need further information regarding these comments, please contact me at our center. My phone number is816-931-3116 and my e-mail is jrichmond@nueterra.com.

Very Truly Yours,
Jennifer Richmond, RN

Administrator
Columbia Endoscopy Center
208 Portland Street
Columbia, MO 65201

Issues

Proposed Additions to the list of ASC covered procedures.

43237
43238
43257
45330

Proposed Deletions from the list of ASC covered procedures.

Submitter : **Ms. Tabatha Crace** **Date: 12/21/2004**

Organization : **Findlay Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Additions to the list of ASC covered procedures.

52000 and 52281

Submitter : **Mr. Charles I Busack** **Date: 12/21/2004**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Additions to the list of ASC covered procedures.

Comments on the proposed addition of CPT Code 57288 and the proper payment group it should be assigned to.

CMS-1478-P-35-Attach-1.DOC

CMS-1478-P-35-Attach-1.DOC

Submitter : **Dr. Samuel Storch** **Date: 12/24/2004**

Organization : **Mid Carolina Urology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Deleting these codes from the approved ASC list would be counterproductive in relation to cost effectiveness and patient safety. Although these procedures are most often performed in the physician office setting, there are patients, due to their medical condition, who cannot be safely treated in the office. This distinction can and should only be made by the physician. If these codes are deleted then these special needs patients will be treated in the more costly setting of a hospital outpatient department.

Issues

Proposed Deletions from the list of ASC covered procedures.

CPT 52000, 52281, 55700

Submitter : **Date: 12/27/2004**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Deleting these procedures from the ASC list is reverting back to antiquated methods and would impede our ability to provide quality care to our patients, reduce patients? satisfaction, and stymie our ability to provide the type of care that has become standard. I urge you and all those considering this issue to examine my points closely as I perform these procedures on a daily basis and welcome any further discussion regarding this topic.

Issues

Proposed Deletions from the list of ASC covered procedures.

In my thirty years of practice as a urologist, I can state with confidence that the following procedures are more effectively performed within an ASC environment: Cystoscopy (HCPCS code 52000), Cystoscopy and treatment (HCPCS code 52281), Prostatic microwave thermotx (HCPCS code 53850), and Biopsy of prostate (HCPCS code 55700). The ASC presents a clear upgrade over an environment that was and is below the current standards of care and patient expectations. Within the ASC setting, we monitor critical health parameters such as heart rate, blood pressure, and oxygenation that help to prevent adverse, long-term effects that these procedures can have on patients. For example, I have known cases in which a patient had a hypotensive episode which lead into renal failure, cardiac arrest, and stroke ? all of which we as medical providers can better prevent in a tightly monitored ASC setting.
By monitoring these critical health metrics, we also have the capability to act more prudently regarding unanticipated, urgent patient needs. For example, a patient underwent a prostate biopsy and became violently ill, but we were able to anticipate and prevent undue consequences as we were monitoring his health through these critical metrics. Cases like these require the expertise and updated facilities of an ASC to be able to manage them effectively.
In addition to providing an enhanced level of customer care, patients prefer to have these procedures in an ASC. As I work in a unique environment that includes both a traditional medical office and ASC, I have noted that the satisfaction rate for these procedures in the ASC is significantly higher than those in a traditional office. Empirical data indicates that the satisfaction rate for our ASC patients is close to 92%, which is well above the rate for these same procedures in our traditional medical office. The patients have also provided glowing personal comments regarding the new environment, specifically citing an enhanced level of comfort, care, and safety. The most glowing commendation for the ASC is that 100% of our patients would both recommend the surgery center to friends and use the surgery center again for these procedures.

Submitter : **Ms. Angela Richberg** **Date: 12/28/2004**

Organization : **Specialty Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Issues

Proposed Additions to the list of ASC covered procedures.

Specialty Surgery Center has 18 Credentialed Urologists, therefore I am extremely interested in the proposals relating to adding the bladder sling (CPT 57288) for stress incontinence to the ASC approved codes. I applaud your decision. This decision is truly in the patients best interest. I would like to comment on the cost of the procedure. As I am sure you are aware, this procedures requires the insertion of a 'sling' - thus the name - the cost of the sling can range, depending on the brand, from $695.00 to $995.00. I will look forward to your recommendation for reimbursement at Group 5 or Group 9? You acknowledge that there are 'resources required to perform this procedure'. As an Administrator of a ASC, I feel very strongly about being able to cover the cost of expensive 'resources' - in this case the actual sling. I would suggested that the ruling provide a payment grouper (5 or 9 in this case) and also a carve-out to cover the cost of the sling. You will find that you will in the long run save money by this method of payment. Your Urologists and my fellow Administrators will welcome these patients with open arms. There are some ASC's (probably the majority) that will not be in a financial position to perform these procedures without appropriate reimbursement. For the ASC that cannot absorb this expensive item - you will be again in a position that requires you pay for a hospital surgical visit and that in itself has defeated your purpose.

Proposed Deletions from the list of ASC covered procedures.

I am, on the other hand, extremely concerned about the proposals to delete CPT codes 52000, 52281, 55700. Therefore to better represent our patients wants and desires we conducted a Performance Improvement the week of December 13-17. During this survey process we asked our patients two questions. The surveys were presented to our patients who were having CPT codes 52000, 52281 and 55700. After you have reviewed the findings, I hope that you will have a better understading of what patients really would like to see from their insurance provider.

The survey represented 36 of our urology patients, having the procedures in question. Question 1 simply asked if the patients if they could not come to the ASC for their procedure, would they prefer to go to the Hospital or the Physicians office. Of the 36 patients surveyed 30 patients preferred the ASC, 6 stated that they would go to the Hospital, none stated that they would prefer the office. (Wouldn't the Hospital be more costly?)

The second question asked if the patient preferred having the procedure in an ASC setting. 36 out of 36 patients polled preferred the ASC. I am wondering in the report of recommendations from the HHS Office of the Inspector General (OIG) to CMS - who would benefit from not allowing these patients to have their procedures in a setting that is controlled, patient friendly, patient safe and cost effective to your organization? Are they considering the patient, afterall, the patient is the one directly affected by the medical condition being treated, not CMS. If I can be of further assistance or help in anyway with this process, please do not hesitate to contact me. Angela Richberg, BA RN CASC CAPPM, Administrator, Specialty Surgery Center, 7250 Cathedral Rock Las Vegas, NV 89128 702 596-3947 or 702 304-3978.

Submitter : **Mrs. Carri Balk** **Date: 12/28/2004**

Organization : **Walla Walla Clinic Ambulatory Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

I would like to voice my concern over the proposed deletion of two specific coding areas of procedures that are present on the list at this time. We are a small multispecialty ASC that completes aprox. 2000 surgeries/procedures per year. Of these 41 (in 2004) were specific to tissue transfer or flap repair (codes 14040 through 15740)on Medicare patients. Also 134 were specific to cystocpies of one kind or another (codes 52000 and 52281). The tissue procedures were performed on elderly, healty patients that needed heavier sedation due to type of procedure than was safe in an office setting, but could be safely done at a lower cost to Medicare in our facility as compared to the cost at an area hospital. In regards to the cysto patients, our urologist would have to schedule these patients at an area hospital with a greatly increased charge to Medicare. Our ASC has had NO reported complications from any of the 175 cases we have completed in 2004 under these codes. Please consider leaving these codes on the approved Medicare code list. Thank you. Carri Balk, RN, Director WWCASC

Submitter : **Dr. Joseph Cambio** **Date: 12/29/2004**

Organization : **RI Urological Specialties**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Removing CPT codes 52000, 52281 and 55700 from the ASC coverage list is a terribly misguided decision. Although most of these procedures may be performed in an office setting there are many that MUST be done in a higher level setting due to the patients' conditions (eg., patient with metal prosthesis, underlying cardiac problem). Contrary to the government's belief these cases will not be shifted to an office setting, but rather to a higher cost hospital setting. It is purely a matter of patient safety. Please reconsider this very short-sighted proposal.

Joseph C. Cambio, M.D.
Vincent A. Catallozzi, M.D.
Daniel C. Jaffee, M.D.
Brian S. McLeod, M.D.

Submitter : **Dr. scott haupt** **Date: 12/30/2004**

Organization : **Dr. scott haupt**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

While trying to schedule cases at any surgery Center, I have been unable to schedule a smaller cancer excisions and had to move the case to a hospital because they were not allowed at the surgery Center. Most of these require a frozen section diagnosis for adequate cancer removal. If smaller I will do this in the office, but when a frozen section is required or a flap is required to cover the area in certain locations such as around the eyelid I feel very uncomfortable performing the procedure he my office where I do not have adequate cauterization and hemostasis control and patient movement control with anesthesia. In allowing codes 11601 ,11602, and 11603, this would be appropriate if a frozen section diagnosis is required at the same time. Currently if I wish to do these in a surgery Center I must use any skin flap code such as 14040. This also increase the cost, but I am trapped because if I do not use this code the surgery may not be paid for both to myself, surgery Center, and caused the patient being responsible for the bill.

CMS has proposed that the following codes be deleted from authorization for utilization at any surgical Center; These include 11404, 11424, 11444-6, 11604, 11624, 11644. All of these lesions are > 3 cm. If these are not able to be performed at a surgery Center, then they must be done and hospital at an increase cost. These are too large to be done in an office where no hemostatic control device is available. It also limits the reconstructive options, which can include skin grafts or local flaps or tissue advancement whose codes also are to be eliminated. These reconstructive codes for closure included CPT shows 13100-1, 13120-1, 13131-2, 13150-2, 14000, 14020-1, 14040-1, 14060-1. It is probably the assumption that these codes can be done in an office, and they cannot be without adequate hemostatic control and patient control with anesthesia. Anything less increases the risk to the patient and to the procedure and outcome of the procedure. I cannot do these procedures in the office, and taking them to a hospital does increase the cost to Medicare. For patient safety and economics these codes should be still available at a more cost-effective surgery Center

Issues

Proposed Additions to the list of ASC covered procedures.

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Submitter : **Dr. John Sislow** **Date: 12/31/2004**

Organization : **Walla Walla Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. John Ellis** **Date: 01/03/2005**

Organization : **Midwest Ear Nose and Throat Center, P.C.**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

December 22, 2004

Dear Sir or Madam:

Please accept these comments concerning the CMS proposed rule with comment period ending January 25, 2005, regarding additions to and deletions from the list of approved ambulatory surgical procedures (ACS list).

Our ambulatory surgery center is located at Independence, Missouri and has been in operation for two years. We are commenting on the proposed changes because our review of these changes indicates that the procedures listed below should remain on the approved listing.

We are requesting the following codes which are included in the proposed deletion list not be deleted. Our concern and reasoning is noted as well.

CPT code 41112 is excision of a tongue lesion in the anterior two-thirds of the tongue. Although these lesions are usually done outpatient, they are most commonly done using general anesthetic and not usually in the office.

CPT code 21325 open reduction of nasal fracture. The open reduction requires osteotomies and sometimes a nasal reconstruction and is not done in the office. This procedure is usually done as an outpatient, but most commonly done with IV sedation or general anesthesia.

CPT code 42860 excision of tonsil tags is rarely an office procedure and is generally done under general anesthetic as an out-patient procedure.

Thank you for your time and consideration of our requests. If you need further information regarding these comments, please contact me. My phone number is 816-478-4200.

Very truly yours,

John C. Ellis, M.D., F.A.C.S.

WBM/JCE/dd

Submitter : **Dr. William Mangum** **Date: 01/03/2005**

Organization : **Midwest Ear Nose and Throat Center, P.C.**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

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Thank you for your time and consideration of our requests. If you need further information regarding these comments, please contact me. My phone number is 816-478-4200.

Very truly yours,

William B. Mangum, M.D., F.A.C.S.

WBM/dd

Submitter : **Dr. Kelvin Walls** **Date: 01/03/2005**

Organization : **Midwest Ear Nose & Throat Center, P.C.**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

December 22, 2004

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We are requesting the following codes which are included in the proposed deletion list not be deleted. Our concern and reasoning is noted as well.

CPT code 41112 is excision of a tongue lesion in the anterior two-thirds of the tongue. Although these lesions are usually done outpatient, they are most commonly done using general anesthetic and not usually in the office.

CPT code 21325 open reduction of nasal fracture. The open reduction requires osteotomies and sometimes a nasal reconstruction and is not done in the office. This procedure is usually done as an outpatient, but most commonly done with IV sedation or general anesthesia.

CPT code 42860 excision of tonsil tags is rarely an office procedure and is generally done under general anesthetic as an out-patient procedure.

Thank you for your time and consideration of our requests. If you need further information regarding these comments, please contact me. My phone number is 816-478-4200.

Very truly yours,

Kelvin Walls, M.D.

WBM/KLW/dd

Submitter : **Dr. Andrew Pavlovich** **Date: 01/03/2005**

Organization : **Midwest Ear Nose & Throat Center, P.C.**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

December 22, 2004

Dear Sir or Madam:

Please accept these comments concerning the CMS proposed rule with comment period ending January 25, 2005, regarding additions to and deletions from the list of approved ambulatory surgical procedures (ACS list).

Our ambulatory surgery center is located at Independence, Missouri and has been in operation for two years. We are commenting on the proposed changes because our review of these changes indicates that the procedures listed below should remain on the approved listing.

We are requesting the following codes which are included in the proposed deletion list not be deleted. Our concern and reasoning is noted as well.

CPT code 41112 is excision of a tongue lesion in the anterior two-thirds of the tongue. Although these lesions are usually done outpatient, they are most commonly done using general anesthetic and not usually in the office.

CPT code 21325 open reduction of nasal fracture. The open reduction requires osteotomies and sometimes a nasal reconstruction and is not done in the office. This procedure is usually done as an outpatient, but most commonly done with IV sedation or general anesthesia.

CPT code 42860 excision of tonsil tags is rarely an office procedure and is generally done under general anesthetic as an out-patient procedure.

Thank you for your time and consideration of our requests. If you need further information regarding these comments, please contact me. My phone number is 816-478-4200.

Very truly yours,

Andrew S. Pavlovich, M.D., F.A.C.S.

WBM/ASP/dd

Submitter : **Dr. Frederick Hahn** **Date: 01/04/2005**

Organization : **Midwest Ear Nose and Throat Center, PC**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

December 22, 2004

Dear Sir or Madam:

Please accept these comments concerning the CMS proposed rule with comment period ending January 25, 2005, regarding additions to and deletions from the list of approved ambulatory surgical procedures (ACS list).

Our ambulatory surgery center is located at Independence, Missouri and has been in operation for two years. We are commenting on the proposed changes because our review of these changes indicates that the procedures listed below should remain on the approved listing.

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Thank you for your time and consideration of our requests. If you need further information regarding these comments, please contact me. My phone number is 816-478-4200.

Very truly yours,

Frederick W. Hahn, Jr., M.D., F.A.C.S.

WBM/FWH/dd

Submitter : **Dr. Richard Fichman** **Date: 01/06/2005**

Organization : **Fichman Eye Center**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

. A new procedure code, 66711, (Eye and Ocular Adnexa/Surgery, Iris, Ciliary Body, Destruction, Ciliary body destruction; diathermy, cyclophotocoagulation, endoscopic) was added to the AMA CPT2005 list for FY 2005. This surgery must take place in a surgical suite; it cannot be performed in an office setting. The patient must be under anesthesia, sterile procedures are required, an incision is made in the eye, and the procedure is similar in preparation, duration and skill as cataract surgery. Most of the eye surgery procedures in the CPT2005 manual are on the approved ASC list--with very few exceptions.
In looking at the Regulatory Requirements, we do believe that the addition of this code meets the criteria as follows:
The surgery is commonly performed on an inpatient basis but may be safely performed in an ASC. It is performed inside the eye and definitely can not be completed in an office setting.
Not of a type that is commonly performed or that may be safely performed in physicians offices
It requires a dedicated operating suite and requires a post-operative short term convalescent room It is not excluded from Medicare coverage
The procedure does not exceed 90 minutes operating time nor four hours recovery time
The anesthesia used is local or regional and is not of more than 90 minutes duration
There is generally no extensive blood loss, nor is their major or prolonged invasion of body cavities, that directly involve major blood vessels or that are generally emergency or life-threatening in nature

We believe this meets the criteria for consideration and ask that you review the procedure for inclusion in the list of ASC covered procedures.

Thank you for your consideration.

Submitter : **Date: 01/06/2005**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Issues

Proposed Deletions from the list of ASC covered procedures.

Proposed Medicare Procedure Deletions from Ambulatory Surgery Centers.

We have been informed that CMS is considering deletion of a number of procedures currently approved by Medicare for Ambulatory Surgery Centers. We want to encourage you in the strongest terms possible to not proceed with the planned deletions of these cases from the Medicare approved ASC list. The CPT codes that we are particularly concerned about are as follows:

14040
14060
14061
15732
15740
26605
52000
52281

Deletion of these procedures is financially unwise and is unnecessary from a quality perspective. As the government attempts to reduce the deficit and provide for the long-term financial viability of Medicare, moving these cases out of a less expensive, high-quality Ambulatory Surgery Center and into a more expensive hospital setting makes no financial sense. In addition, many private insurance carriers often follow Medicare?s lead in deciding what is performed inside an Ambulatory Surgery Center. If private insurance carriers follow Medicare?s lead, then this will only result in higher health care costs for the entire population. Public outcry should be expected regarding government actions that simply drive health care costs higher without improving quality.

Our Ambulatory Surgery Center conducted a review of the procedures listed above and determined that we had no complications regarding these procedures. Therefore, there is no quality benefit to be gained from moving these out of an Ambulatory Surgery Center and into a hospital setting or physician?s office. In fact, given that our complication rate tends to be lower than both hospitals and private office settings one can make a case that you are actually diminishing quality by deleting these procedures from an Ambulatory Surgery Center.

Finally, these cases represent nearly 10% of our total case volume. Ambulatory Surgery Centers are typically much less expensive than the cost of performing the same procedure in a hospital outpatient surgery department. Ambulatory Surgery Centers are able to maintain this lower cost, in part, by having a sufficient volume of procedures to make the Surgery Center financially viable. Removing cases from this more cost effective setting simply makes it more difficult for a Surgery Center to continue to operate. If Surgery Centers cannot be financially viable, then that will be another factor in driving health care costs to a higher level.

Once again, we hope that you will seriously reconsider deletion of these cases that will only serve to drive health care costs higher and have either a neutral or negative impact on quality.

Submitter : **Dr. Richard Berlin** **Date: 01/06/2005**

Organization : **Dr. Richard Berlin**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly oppose the proposed Medicare cuts for plastic surgery procedures in ambulatory surgery centers. These proposed cuts will have a very negative impact on surgical treatment for skin cancer. If these cuts occur, patients will continue to need skin cancer surgery, but will have limited options for treaters and treatment locations. Ambulatory surgery centers provide a safe, confidential alternative for patients seeking care outside a hospital. Ambulatory surgery centers have been shown to save money to health care systems, and have a safety profile equivalent if not superior to hospitals. I therefore urge you to continue to re-imburse ambulatory surgery centers for plastic surgery procedures.

Submitter : **Mrs. Sharon DeCanio** **Date: 01/06/2005**

Organization : **Island Eye Surgicenter**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-51-Attach-1.DOC

Submitter : **Dr. brent clark** **Date: 01/06/2005**

Organization : **walla walla clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1478-P
P.O. Box 8013
Baltimore, MD 21244-8013

To Whom It May Concern:

We have been informed that CMS is considering deletion of a number of procedures currently approved by Medicare for Ambulatory Surgery Centers. We want to encourage you in the strongest terms possible to not proceed with the planned deletions of these cases from the Medicare approved ASC list. The CPT codes that we are particularly concerned about are as follows:
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14060
14061
15732
15740
26605
52000
52281
Deletion of these procedures is financially unwise and is unnecessary from a quality perspective. As the government attempts to reduce the deficit and provide for the long-term financial viability of Medicare, moving these cases out of a less expensive, high-quality Ambulatory Surgery Center and into a more expensive hospital setting makes no financial sense. In addition, many private insurance carriers often follow Medicare?s lead in deciding what is performed inside an Ambulatory Surgery Center. If private insurance carriers follow Medicare?s lead, then this will only result in higher health care costs for the entire population. Public outcry should be expected regarding government actions that simply drive health care costs higher without improving quality.

Our Ambulatory Surgery Center conducted a review of the procedures listed above and determined that we had no complications regarding these procedures. Therefore, there is no quality benefit to be gained from moving these out of an Ambulatory Surgery Center and into a hospital setting or physician?s office. In fact, given that our complication rate tends to be lower than both hospitals and private office settings one can make a case that you are actually diminishing quality by deleting these procedures from an Ambulatory Surgery Center.

Finally, these cases represent nearly 10% of our total case volume. Ambulatory Surgery Centers are typically much less expensive than the cost of performing the same procedure in a hospital outpatient surgery department. Ambulatory Surgery Centers are able to maintain this lower cost, in part, by having a sufficient volume of procedures to make the Surgery Center financially viable. Removing cases from this more cost effective setting simply makes it more difficult for a Surgery Center to continue to operate. If Surgery Centers cannot be financially viable, then that will be another factor in driving health care costs to a higher level.

Once again, we hope that you will seriously reconsider deletion of these cases that will only serve to drive health care costs higher and have either a neutral or negative impact on quality.

Sincerely yours,
Dr. Brent Clark

Issues

Proposed Additions to the list of ASC covered procedures.

28899- MBA implant, subtalar arthroeresis, needs its own code rather than unlisted code

Submitter : **Mr. Robert Goldstein** **Date: 01/06/2005**

Organization : **Mr. Robert Goldstein**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I strongly oppose the proposed Medicare cuts for plastic surgery procedures in ambulatory surgery centers. These proposed cuts will have a very negative impact on surgical treatment for skin cancer. If these cuts occur, patients will continue to need skin cancer surgery, but will have limited options for treaters and treatment locations. Ambulatory surgery centers provide a safe, confidential alternative for patients seeking care outside a hospital. Ambulatory surgery centers have been shown to save money to health care systems, and have a safety profile equivalent if not superior to hospitals. I therefore urge you to continue to re-imburse ambulatory surgery centers for plastic surgery procedures.

Submitter : **Dr. peter bentivegna** **Date: 01/10/2005**

Organization : **ccphs**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Many of the proposed deletions of ASC codes would decrease the access to care for lMedicare patients and increase the waiting periods as cases would need to return to the expensive inefficient and pooorly run hospital operating rooms. The skin closure, reconstruction flap codes, and hand cyst codes are particularly troublesome to hand surgeons and reconstructive plastic surgeons.. This is one more example of punishing the docs who take care of the problems and further reason to restrict our practices to cosmetic, non insurance, unregulated patient care.

Submitter : **Dr. Michael Cruz** **Date: 01/11/2005**

Organization : **Spokane ENT**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Sinus endoscopy codes 31233, 31235, 31237,31238, should be covered ASC procedures. The OIG should consult with the Academy of Otolaryngology and Head and Neck surgery, and the American Rhinologic Society regarding the statistics to support this as a safe outpatient procedure. Also skin lesion removal and repair of wound or lesion codes should be covered as ASC cases as with other coexisting diagnoses such as age or mental status as requirements for ASC usage.

41520,41800,41827,42000,42107 CPT codes should be covered in ASC as most drainage procedures intraorally require airway protection in the way of LMA, or endotracheal tube.

Thank you

Submitter : **Dr. Thomas Stringer** **Date: 01/11/2005**

Organization : **Citrus Urology Associates**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

See Attachment

CMS-1478-P-56-Attach-1.DOC

Submitter : **Date: 01/11/2005**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

December 15, 2004

Centers for Medicare and Medicaid Services

To Whom It May Concern:

I am writing in regard to the recent list of surgical procedure codes indicating codes that were scheduled to be deleted for ambulatory surgery centers. I am a physician who performs surgery at the Ambulatory Surgery Center in Sandwich, Massachusetts. We perform over 7000 procedures at our center each year and there are over 70,000 procedures performed each year at ambulatory surgery centers statewide. Our center is inspected and certified by AAAHC which has criteria at least as strict as those for in-patient hospitals. Furthermore, we are very selective about which surgeons are allowed to practice at our center in order to maintain the highest quality of care. Our patient satisfaction surveys are rated as outstanding/good in over 98% of the responses. We provide multi-specialty services including ophthalmology, plastic surgery, general surgery, otolaryngology, urology, gynecology, gastroenterology and orthopedics.
The removal of the surgical procedure codes listed below would significantly impact patients and ambulatory surgery centers throughout the country. Ambulatory surgery centers provide high quality care at a significantly reduced cost to care received in the hospital setting. The apparent logic behind eliminating the surgical procedure codes is to drive many procedures back to the physician?s office to reduce costs but this would have the opposite effect. Our physicians all believe that if they are not able to do these procedures in the ambulatory surgery center then they would be forced to do them in a hospital setting which would dramatically drive up the costs to the insurance providers and result in significant inconvenience to our patients.

Please reconsider deleting the surgical procedure codes for ambulatory surgery centers and let us maintain the high-quality and cost-efficient surgery center that we have worked so hard to establish.

Sincerely,

Keith McAteer MD FACOG

Issues

Proposed Deletions from the list of ASC covered procedures.

HCPCS	Short Descriptor	Rationale	HCPCS	Short Descriptor	Rationale
11404	Removal of skin lesion	4	27808	Treatment of ankle fracture	4
11424	Removal of skin lesion	4	28400	Treatment of heel fracture	4
11444	Removal of skin lesion	4	30801	Cauterization, inner nose	4
11446	Removal of skin lesion	4	30915	Ligation, nasal sinus artery	2
11604	Removal of skin lesion	4	30920	Ligation, upper jaw artery	2
11624	Removal of skin lesion	4	31233	Nasal/sinus endoscopy, dx	4
11644	Removal of skin lesion	4	31235	Nasal/sinus endoscopy, dx	4
12021	Closure of split wound	4	31237	Nasal/sinus endoscopy, surg	4
13100	Repair of wound or lesion	4	31238	Nasal/sinus endoscopy, surg	4
13101	Repair of wound or lesion	4	38505	Ndle biopsy, lymph nodes	4
13120	Repair of wound or lesion	4	40700	Repair cleft lip/nasal	2
13121	Repair of wound or lesion	4	40701	Repair cleft lip/nasal	2
13131	Repair of wound or lesion	4	40814	Excise/repair mouth lesion	4
13132	Repair of wound or lesion	4	41009	Drainage of mouth lesion	1
13150	Repair of wound or lesion	4	41010	Incision of tongue fold	1

13151 Repair of wound or lesion 4
13152 Repair of wound or lesion 4
14000 Skin tissue rearrangement 4
14020 Skin tissue rearrangement 4
14021 Skin tissue rearrangement 4
14040 Skin tissue rearrangement 4
14041 Skin tissue rearrangement 4
14060 Skin tissue rearrangement 4
14061 Skin tissue rearrangement 4
15732 Muscle-skin graft, hd/neck 2
15734 Muscle-skin graft, trunk 2
15738 Muscle-skin graft, leg 2
15740 Island pedicle flap graft 4
19100 Bx breast percut w/o image 4
20670 Removal of support implant 4
21040 Removal of jaw bone lesion 1
21050 Removal of jaw joint 2
21206 Reconstruct upper jaw bone 1
21210 Face bone graft 1
21249 Reconstruction of jaw 1
21325 Treatment of nose fracture 1
21355 Treat cheek bone fracture 1
21440 Treat dental ridge fracture 1
21485 Reset dislocated jaw 1
22305 Treat spine process fracture 4
23600 Treat humerus fracture 4
23620 Treat humerus fracture 4
24576 Treat humerus fracture 1
24670 Treat ulnar fracture 4
25505 Treat fracture of radius 1
26605 Treat metacarpal fracture 4
27520 Treat kneecap fracture 4
27760 Treatment of ankle fracture 4
27780 Treatment of fibula fracture 4
27786 Treatment of ankle fracture 4
41112 Excision of tongue lesion 4
41520 Reconstruction, tongue fold 1
41800 Drainage of gum lesion 1
41827 Excision of gum lesion 1
42000 Drainage mouth roof lesion 1
42107 Excision lesion, mouth roof 1
42200 Reconstruct cleft palate 2
42205 Reconstruct cleft palate 2
42210 Reconstruct cleft palate 2
42215 Reconstruct cleft palate 2
42220 Reconstruct cleft palate 2
42409 Drainage of salivary cyst 1
42425 Excise parotid gland/lesion 3
42860 Excision of tonsil tags 1
42892 Revision pharyngeal walls 3
52000 Cystoscopy 4
52281 Cystoscopy and treatment 4
53850 Prostatic micrwve thermotx 1
55700 Biopsy of prostate 4
58820 Drain ovary abscess, open 3
60000 Drain thyroid/tongue cyst 1
64420 N block inj, intercost, sng 4
64430 N block inj, pudendal 1
64736 Incision of chin nerve 1
65800 Drainage of eye 1
65805 Drainage of eye 4
67141 Treatment of retina 4
68340 Separate eyelid adhesions 1
68810 Probe nasolacrimal duct 4
69145 Remove ear canal lesion(s) 4
69450 Eardrum revision 2
69725 Release facial nerve 1
69740 Repair facial nerve 2
69745 Repair facial nerve 2
69840 Revise inner ear window 1

Submitter : **Dr. Jay B. Miller** **Date: 01/11/2005**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on CPT codes 52000, 52281 and 55700.

CMS-1478-P-58-Attach-1.DOC

CMS-1478-P-58-Attach-1.DOC

Submitter : **Dr. Basil Michaels** **Date: 01/11/2005**

Organization : **Berkshire Cosmetic & Reconstructive Surgery Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

11604 Removal of skin lesion 4
11624 Removal of skin lesion 4
11644 Removal of skin lesion 4
12021 Closure of split wound 4
13100 Repair of wound or lesion 4
13101 Repair of wound or lesion 4
13120 Repair of wound or lesion 4
13121 Repair of wound or lesion 4
13131 Repair of wound or lesion 4
13132 Repair of wound or lesion 4
13150 Repair of wound or lesion 4
13151 Repair of wound or lesion 4
13152 Repair of wound or lesion 4
14000 Skin tissue rearrangement 4
14020 Skin tissue rearrangement 4
14021 Skin tissue rearrangement 4
14040 Skin tissue rearrangement 4
14041 Skin tissue rearrangement 4
14060 Skin tissue rearrangement 4
14061 Skin tissue rearrangement 4

CMS-1478-P-59-Attach-1.DOC

CMS-1478-P-59-Attach-1.DOC

Submitter : **Ms. Debbie Phelps** **Date: 01/11/2005**

Organization : **Berkshire Cosmetic & Reconstructive Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

Issues

Proposed Deletions from the list of ASC covered procedures.

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13150 Repair of wound or lesion 4
13151 Repair of wound or lesion 4
13152 Repair of wound or lesion 4
14000 Skin tissue rearrangement 4
14020 Skin tissue rearrangement 4
14021 Skin tissue rearrangement 4
14040 Skin tissue rearrangement 4
14041 Skin tissue rearrangement 4
14060 Skin tissue rearrangement 4
14061 Skin tissue rearrangement 4

CMS-1478-P-60-Attach-1.DOC

CMS-1478-P-60-Attach-1.DOC

Submitter : **Ms. Valerie Toomey** **Date: 01/11/2005**

Organization : **Berkshire Cosmetic & Reconstructive Surgery Center**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

Issues

Proposed Deletions from the list of ASC covered procedures.

11604 Removal of skin lesion 4
11624 Removal of skin lesion 4
11644 Removal of skin lesion 4
12021 Closure of split wound 4
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14000 Skin tissue rearrangement 4
14020 Skin tissue rearrangement 4
14021 Skin tissue rearrangement 4
14040 Skin tissue rearrangement 4
14041 Skin tissue rearrangement 4
14060 Skin tissue rearrangement 4
14061 Skin tissue rearrangement 4

CMS-1478-P-61-Attach-1.DOC

CMS-1478-P-61-Attach-1.DOC

Submitter : **Mr. Bruce Dube** **Date: 01/11/2005**

Organization : **Berkshire Cosmetic & Reconstructive Surgery Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

11604 Removal of skin lesion 4
11624 Removal of skin lesion 4
11644 Removal of skin lesion 4
12021 Closure of split wound 4
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13150 Repair of wound or lesion 4
13151 Repair of wound or lesion 4
13152 Repair of wound or lesion 4
14000 Skin tissue rearrangement 4
14020 Skin tissue rearrangement 4
14021 Skin tissue rearrangement 4
14040 Skin tissue rearrangement 4
14041 Skin tissue rearrangement 4
14060 Skin tissue rearrangement 4
14061 Skin tissue rearrangement 4

Submitter : **Mrs. Gail Brown** **Date: 01/11/2005**

Organization : **Berkshire Cosmetic & Reconstructive Surgery Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am a skin care specialist for Berkshire Cosmetic & Reconstructive Surgery Center a Medicare approved ambulatory surgical facility in Pittsfield, Massachusetts. I am very concerned about the Medicare cuts the attorney general is proposing for the ambulatory surgery centers. I am responsible for preparing the patients for surgery and I feel the patient should have a choice as to where they would like their surgery for many reasons. One reason is that we can schedule the surgery much sooner than we can at the hospitals in Berkshire County. The patient is less anxious not having to go to the hospital and the infection rate is much lower in our facility compared to the Hospital. In this past year alone we had 197 patients with Medicare that had to have skin cancers removed in our operating room. That does not include the patients with other insurances or all of the patients that were done at the hospital. Our surgeons scheduling at Berkshire Medical Center is very limited, which means the patient has to wait several weeks before having their surgery, in turn makes the patient much more anxious. As an employee of Berkshire Cosmetic & Reconstructive Surgery Center and a tax payer in this community I feel we should have a choice.

Issues

Proposed Deletions from the list of ASC covered procedures.

11604 Removal of skin lesion 4
11624 Removal of skin lesion 4
11644 Removal of skin lesion 4
12021 Closure of split wound 4
13100 Repair of wound or lesion 4
13101 Repair of wound or lesion 4
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13150 Repair of wound or lesion 4
13151 Repair of wound or lesion 4
13152 Repair of wound or lesion 4
14000 Skin tissue rearrangement 4
14020 Skin tissue rearrangement 4
14021 Skin tissue rearrangement 4
14040 Skin tissue rearrangement 4
14041 Skin tissue rearrangement 4
14060 Skin tissue rearrangement 4
14061 Skin tissue rearrangement 4

Submitter : **Dr. George Csank** **Date: 01/11/2005**

Organization : **Berkshire Cosmetic & Reconstructive Surgery Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

11604 Removal of skin lesion 4
11624 Removal of skin lesion 4
11644 Removal of skin lesion 4
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13152 Repair of wound or lesion 4
14000 Skin tissue rearrangement 4
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14021 Skin tissue rearrangement 4
14040 Skin tissue rearrangement 4
14041 Skin tissue rearrangement 4
14060 Skin tissue rearrangement 4
14061 Skin tissue rearrangement 4

CMS-1478-P-64-Attach-1.DOC

CMS-1478-P-64-Attach-1.DOC

Submitter : **Dr. alan Pokorny** **Date: 01/13/2005**

Organization : **Spokane ENT, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I have reviewed the list of proposed codes to be deleted and the rationale. For virtually all of these codes for which I am familiar (I am an otolarygologist) the proposed deletions and their rationales border on the ridiculous. For example, many of the skin surgery codes (11404 - 14060) are performed in the office, but occaisionally these procedures need to be done in in operating room setting to provide patient comfort, safety, or for multiple procedures. One can not arbitrarily say that they should never be done in an ASC. Likewise, the sinus endoscopy codes (particularly 31237 and31238) are frequently done in the office, but when they are done in an operating room, they really need to be there. If I am unable to do these things in an outpatient center, they will need to be done in a hospital, which will triple costs, which seems to me to be a bad idea. Likewise, some procedures are typically done in in inpatient setting (code 42425), but not necessarily so, so why eliminate the option of doing this at an outpatient center. Finally to say that certain procedures are usually done in the physicians' office (codes 21325-21355) is erroneous. I know of no physician who routinely performs these in their office. One must put thenmselves in the patient's position: Where would you want to have you nose fixed? For me, the answer is unequivocally in a surgery center.

Submitter : **Dr. Mark Uhlman** **Date: 01/13/2005**

Organization : **Dr. Mark Uhlman**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

Regarding addition of CPT code 57288:

Table one in CMS-1478-PN shows that 57288 will be added with a payment schedule in group 5 ($717) while the Revised list on page 88 of the same document shows it will be reimbursed at group 9 ($1339)

Since this procedure requires biologic compatable graft or synthetic graft material typically costing $600 - $900 it would be unrealistic to set a payment schedule in group 5 ($717) Please recogize this inconsistancy and properly reimburse this procedure at group 9 ($1339) Thank you.

Submitter : Dr. Stuart Masters **Date:** 01/14/2005

Organization : Berkshire Radiological Associates, PC

Category : Radiologist

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I am concerned about eliminating funding for 100 procedures performed in Ambulatory Surgery Centers (ASC). If these cuts are enacted, it would force many appropriate outpatient procedures and the majority of skin cancer treatments into hospitals. Presumably, this is your goal. In many communities around the country, there is only one hospital. In our small community of Pittsfield, MA, our only hospital, Berkshire Medical Center, wields huge monopolistic power over its employees, over many of the local doctors, and over the public. If you force these procedures to be done in hospitals, you will accomplish several things, none of which I believe will serve the community well...

First, you will drive excellent ASC's and their doctors out of business in Pittsfield. They will likely leave the area...

Second, you will eliminate patients' choice of doctor and facility. Our hospital's charges are known to be high on both regional and national basis, certainly higher than the ASC's, which is why some of them were created in the first place. For some procedures, ASC surgery is safer than similar procedure in a hospital due to higher infection rates in hospitals. ASC's typically offer quicker, timely appointments, ease of parking, focused care by staff, efficiency of procedures, and lack of delays due to emergencies. The liklihood of finding any of these advantages at our full-service hospital approaches zero...

Third, you will be enhancing the already intrusive monopolistic practices of the sole hospital providor in town. This town has lost many docs over the last few years, largely due to the interference of the hospital in patient care. It is difficult to prove how an entity as big as our towns largest employer (our hospital) intimidates employees, docs, and local businesses. Yet this is the reality of what we have in Pittsfield, MA at this time...

Fourth, you will not be saving Medicare any money. The procedures will be done at the hospital, most likely at higher charges than if they had been done at the ASC's...

I would like to believe that the majority of ASC's across the country are doing an excellent job. I would hope that they charge less than their community's hospitals. If there are a few bad apples, find ways to weed them out. Don't penalize the majority of excellent ASC's, and especially not the ones in Pittsfield, for the acts of a few.

Thank you for your consideration.

Submitter : Dr. Rodney Lenahan **Date:** 01/14/2005

Organization : Dr. Rodney Lenahan

Category : Physician

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I would like to comment on your proposed deletion of 52000 and 55700 from ambulatory surgery reimbursement. Have you ever had one of these procedures done on you? Obviously you do not know that approximately 20% of the patients that have these procedures either need to have this done under anesthesia, or wish that the procedure could be done with anesthesia because of the pain and discomfort that ocassionally may be experienced with these procedures. It would be my recommendation that you continue to leave it up to the doctor and the patient to decide what is in the best interest of the patient. Pay the doctors for what they are doing and let the doctors schedule the procedures where they know the patients need to have them done. In other words, these procedures can be done in the doctor's office, ambulatory surgery, or in the hospital. Why should you step in and decide? Your decisions are often arbitrary. And pay the doctor well to do the procedure whether it is done in the office, ambulatory, or the hospital setting. Thank you.

Submitter : **Dr. Lawrence Anderson** **Date: 01/15/2005**

Organization : **Dermatology Associates of Tyler**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Issues

Proposed Deletions from the list of ASC covered procedures.

See attachment

CMS-1478-P-69-Attach-1.DOC

CMS-1478-P-69-Attach-1.DOC

Submitter : **Date: 01/17/2005**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

Submitter : **Dr. Barry S. Shultz** **Date: 01/17/2005**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on the proposed deletion of CPT codes 52000, 52281 and 55700.

CMS-1478-P-71-Attach-1.DOC

CMS-1478-P-71-Attach-1.DOC

Submitter : **Mr. Alex Odell** **Date: 01/18/2005**

Organization : **Mr. Alex Odell**

Category : **Other Health Care Professional**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

Given the lower cost to operate an ASC, the lower reimburesment paid to an ASC for identical cases performed in hospitals, it seems inconsistent that CMS, possibly under Part A lobby pressure, is cutting back ASC codes vs either adding codes or adding modifiers to codes making an ASC a reasonable option. The extremes of performing procedures in physician offices or a hospital neither reasonably consider patient safety/comfort nor fiscal prudence for the preponderance of cases...both components of prudent medical decision making based on medical necessity.

Proposed Deletions from the list of ASC covered procedures.

Codes 11404 through 69840 represent a significant number of codes that medical necessity requires some level of anesthesia, are less than 90 minutes to perform and less than 4 hrs recovery time, cost CMS less to perform in an ASC than a hospital yet aren't safe to perform in a physician office. Because of the highly varied nature of excision, repair and flap cases (codes 11404 - 14061), and the difficulty in diagnosis prior to lab tests, extenuating medical circumstances such as pt overall health, age, metastasis etc, forcing doctors to decided to perform these cases in either the hospital or their offices increases risk to the pt and/or cost to CMS and probably the pt. What makes the most sense is adding modifiers to these and even more codes, giving doctors better options than currently exist or will exist if this rule change goes into effect April 1.

Submitter : **Dr. W. Jack Lovern** **Date: 01/18/2005**

Organization : **Yakima Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

52000,52281,55700

CMS-1478-P-73-Attach-1.DOC

CMS-1478-P-73-Attach-1.DOC

Submitter : **Dr. W. Jack Lovern** **Date: 01/18/2005**

Organization : **Yakima Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

52000,52281,55700

CMS-1478-P-74-Attach-1.DOC

CMS-1478-P-74-Attach-1.DOC

Submitter : **Dr. W. Jack Lovern** **Date: 01/18/2005**

Organization : **Yakima Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

COMMENT RE CMS-1478-P

PROPOSED DELETIONS for AMBULATORY SURGERY CENTERS

Comment against the ?blanket deletion? of 52000

Deleting 52000 (cystoscopy) from the ASC list may be reasonable for a number of diagnostic codes, but for many diagnostic or symptom codes the ASC is the only clinically appropriate and cost-effective site for cystoscopy ? for although it may be initiated as a simple visual examination (52000), it is frequently converted to a more complex cystoscopic procedure depending on cystoscopic findings. The situation is identical to procedure 44388 (colon endoscopy - which remains on the ASC list of approved procedures, probably because lesions are frequently found that must be biopsied). These more complex invasive procedures require the sterile environment and instruments available within the ASC along with the intravenous sedation capabilities of an ASC ? yet Medicare is billed solely for the more complex cystoscopic (or endoscopic) procedure ? because the examination, whether cystoscopy or colon endoscopy, is folded into the more complex ASC procedural code. If, however, cystoscopy is allowed only in the office many patients undergoing office cystoscopy must then be re-scheduled for a subsequent more complex procedure in the ASC, and Medicare will be billed for two procedures - diagnostic cystoscopy in the office (52000) and the second more complex procedure in the ASC. Therefore deleting 52000 from ASCs as a ?one-size-fits-all? blanket policy, without considering the underlying reason for cystoscopy, will be self-defeating. If cystoscopy is deleted from the ASC list for each and every diagnostic code it will lead to costly duplication of services with unnecessary inconvenience and discomfort for the patient, and there will be inefficient use of physician time. There are, however, diagnostic codes for which cystoscopy in the office setting is appropriate. These codes are for cystoscopic evaluation of pelvic prolapse with or without urinary incontinence (pure stress incontinence) ? but without any degree of hematuria or bladder irritative symptoms such as frequency, urgency, urge incontinence, nocturia or dysuria. When cystoscopy is performed for pelvic prolapse with pure urinary stress incontinence, unaccompanied by other symptoms, then abnormalities requiring more complex cystoscopic procedures are found very infrequently. On the other hand, if there are symptoms or laboratory findings in addition to pure urinary stress incontinence then cystoscopy should be performed in the ASC. Therefore CMS could reasonably selectively delete cystoscopy within ASCs - but only when cystoscopy is performed for diagnostic codes 599.81-599.83, for 618.00-618.09 and for 625.6. These are codes describing bladder prolapse and urinary stress incontinence. I would think local Medicare carriers could adjust their computerized payment programs to reject an ASC billing for cystoscopy whenever it is paired with any one of these diagnostic CPT codes, and require it be billed instead from the doctor?s office. A blanket deletion of 52000 from ASCs, however, will be self-defeating ? for then the overall cost for cystoscopy and cystoscopic procedures will surely rise.

Respectfully submitted,

W. J. Lovern, MD

Issues

Proposed Deletions from the list of ASC covered procedures.

52000

Submitter : **Ms. Kim Brew** **Date: 01/19/2005**

Organization : **Medtronic Xomed, Inc.**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issues

Proposed Additions to the list of ASC covered procedures.

See attachment

CMS-1478-P-76-Attach-1.DOC

CMS-1478-P-76-Attach-1.DOC

Submitter : **Mr. Robert Baird** **Date: 01/19/2005**

Organization : **Samaritan North Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Additions to the list of ASC covered procedures.

See Attachment

Proposed Deletions from the list of ASC covered procedures.

See Attachment

CMS-1478-P-77-Attach-2.DOC

CMS-1478-P-77-Attach-1.DOC

CMS-1478-P-77-Attach-2.DOC

CMS-1478-P-77-Attach-1.DOC

CMS-1478-P-77-Attach-2.DOC

CMS-1478-P-77-Attach-1.DOC

Submitter : **Dr. Robert Gessler** **Date: 01/19/2005**

Organization : **Central Maryland Urology Associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

January 19, 2005

To Whom It May Concern:

This letter is written to state my strong opposition to the removal of codes 52000 (cystoscopy), 52281 (cystoscopy/dilation) and 55700 (prostate biopsy) from the approved CMS ambulatory surgery center procedure list.

By patient and insurance mandate these procedures have been performed safely for years either in an outpatient surgery center or hospital setting. CMS?s proposal to remove these operative surgeries from these locations to an office setting can pose serious problems, both for patients, physicians and staff.

I believe that it is safer to perform these procedures in a surgical setting. When these procedures are performed in an ASC or hospital suite, mechanisms are in place to ensure the proper isolation and disposal of bodily fluids that are the inevitable result of these procedures.

Also in the ASC or hospital setting close, careful monitoring of the patient can be accomplished, such as checking vital signs, oxygen levels and pain levels, all of which are important to patient care and safety. The necessary staff with experience to ensure the safest possible outcome is not available, and cannot be fit into the space available in the doctor?s office. The fact that so many regions of the country are performing these procedures in an inadequate setting should be addressed to improve the situation; this proposal has the country moving backward to inferior care, not forward into the 21st century.

If patients have to wait for hospital access there is typically a four to six week wait in our region. Would you like to wait six weeks to find out if you have prostate cancer? Neither would I. The harm caused by waiting for the results of these procedures will have a significant detrimental impact on medical outcomes. This poses a huge disservice to Medicare patients. Other insured?s will have access to superior and faster health care, how can this be justified?

Please rethink these policies with the patient in mind.

Sincerely,

Robert A. Gessler, M.D., FACS
Clinical Assistant Professor University of Maryland Medical School
Chief of Urology, Howard County General Hospital

Submitter : **Sheri Goff** **Date: 01/19/2005**

Organization : **Spring Park Surgery center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1478-P-79-Attach-1.DOC

Submitter : **Mr. Michael Doyle** **Date: 01/19/2005**

Organization : **Lindsay House Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1478-P-80-Attach-1.DOC

Submitter : **Dr. Malcolm Moore** **Date: 01/19/2005**

Organization : **Eye Center of Central Georgia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

67141 requires a regional anesthetic [typically a retrobulbar block]. Such procedures should be performed in a setting where anesthetic emergencies can be readily managed [such as an ASC]. In addition, in most cases the surgeon must make an incision in the conjunctiva and tenon's to apply the treatment. Such a procedure needs to be performed under sterile conditions, such as in an ASC. 67141 should not be removed from the approved list of procedures to be performed in an ASC.

Issues

Proposed Deletions from the list of ASC covered procedures.

67141 Prophylaxis of retinal detachment without drainage, one or more sesions: cryotherapy, diathermy.

Submitter : **Dr. David Margolin** **Date: 01/19/2005**

Organization : **American Society of Colon and Rectal Surgeons**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Attached is a Word File that presents a table of 21 codes that either are (1) proposed for deletion or (2) shown as 'not approved.' For the latter codes, most of these are new since your last review and we disagree with your decision to not approve. We have also provided a rationale/discussion for each recommendation.

It is our understanding that you have based your decisions solely on a review of site of service frequency in your own database, rather than a clinically-based review. However, many of these services are performed on non-Medicare patients (eg, children) that will require IV sedation or general anesthesia that is not available in an office setting.

We hope that you will agree with our clinically-based rationales and approve all 21 codes for the ASC.

CMS-1478-P-82-Attach-1.DOC

Submitter : **Dr. Michael Crowe** **Date: 01/20/2005**

Organization : **Owensboro Dermatology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Thank you for considering keeping the above codes on the ASC list. If I can be of any further assistance or provide and further information in this matter, please email or call.

Issues

Proposed Deletions from the list of ASC covered procedures.

I would like to propose that you not delete codes 14000, 14020, 14021, 14040, 14041, 14060, 14061, 15740, 13100, 13101, 13120, 13121, 13131, 13132, 13150, from the ASC list.

These codes are for more extensive reconstructive surgery after complicated skin cancer surgery for senior citizens, many of whom have significant medical/cardiac problems. Simple or intermediate closures are already not covered, which is fine. However, this proposed rule would be a mistake because it would put seniors (many who have complicated medical/cardiac and other problems) at risk if these procedures are no longer covered, and then have to be done in a physicians office (with less monitoring, oversight, and overall safety compared to an ASC). Or, if they have to be done in a hospital Operating Room instead of an ASC, this will increase the cost.

Either way, if these codes are removed from the ASC list, seniors and the taxpayers are losers. Please consider keeping them on the list and maintaining quality of care and keeping costs low by keeping these procedures out of the hospital.

Michael J. Crowe, M.D.

Submitter : **Dr. Charles Binder** **Date: 01/20/2005**

Organization : **Individual in private practice**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. Daniel Daley** **Date: 01/20/2005**

Organization : **American Assoc. Of Oral & Maxillofacial Surgeons**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-85-Attach-1.DOC

Submitter : **Dr. Russell Sassani** **Date: 01/20/2005**

Organization : **Take Shape Surgery Center, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. Russell Sassani** **Date: 01/20/2005**

Organization : **Take Shape Surgery Center, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment on Medicare Program: Update of Ambulatory Surgical Center of covered procedures; Proposed rule; 69 Fed. Reg. 69,178

CMS-1478-P-87-Attach-2.DOC

CMS-1478-P-87-Attach-1.DOC

Submitter : **Ms. Sharon Bowen** **Date: 01/20/2005**

Organization : **ENT Surgical Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

As the Administrator of a free-standing ambulatory surgery center specializing in ENT, I would like to comment on the proposed deletions from the ASC approved procedures list. Since Medicaid follows CMS guidelines and my case volume is made of 54% Medicaid (primarily children). In the five years we have been open, we have performed a total of 96 times procedures that are on the proposed deletion list. Our total allowable reimbursement amount would have been $42,092.29 if all the procedures had been performed on Medicare or Medicaid patients. Therefore, my interest is not primarily financial.

The proposed deletions from the list that are ENT procedures are complex procedures requiring general anesthesia and skilled nursing care during the immediate recovery period. Physicians wil not do these procedures in their offices, but in the hospitals where the reimbursement would be substantially more than what it is for an ASC. To deny Medicare and Medicaid recipients access to ASCs where the cost savings are already demonstrated simply is not logical.

Many of the patients on whom we have performed these procedures have significant co-morbidities which would prohibit their being done in the physician's office even if they were not quite painful and extensive. Most specifically, 31237, which is an nasal endoscopy with biopsy or debridement. We performed this procedure a total of 45 times over the five year period we have been open. Most of the patients have been children who have had sinus surgery and need the debridement to reduce scarring in the sinuses. There is no way these procedures could have been performed in an office setting.

Also 21325, which is a open reduction of a nasal fracture. This is certainly not an office procedure since it involves the surgical opening of the nasal cavity to repair a fracture. This procedure is done under general anesthesia. Physician's offices do not have the capability to perform surgery with general anesthesia, nor do they have the skilled staff needed for the care of these patients.

Procedure 14040 has been performed only four times in our facility. One patient on whom this procedure has been performed has a malignant melannoma of the lower lip. The physician is trying to prevent the necessity for doing a significantly more extensive procedure which would make it impossible for this patient to return to work. She would have to go on disability--another drain on the system.

CMS is using outdated methodology for collecting data about these procedures. Perhaps it would be better to work to level the playing field between hospitals and surgery centers with a slightly lower reimbursement for ASCs. That would save significantly more healthcare dollars than deleting procedures form the approved list of ASC procedures.
Feel free to contact me if there are any questions I might answer for you. I can be reached at (912)920-6911.

Submitter : **Mr. Fritz Stephens-Tiley** **Date: 01/20/2005**

Organization : **Willamette Spine Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

RE: Supporting documentation for consideration regarding CMS reimbursement for CPT codes 62290 and 62291 in the ambulatory surgery center setting.

4% of the procedures performed in our surgery center are minimally invasive, pain management and pain modulation in nature. Of these, all of them receive only MAC or conscious sedation. One of the procedures we have been performing on non-Medicare patients is discography (please see descriptions attached). Since January 2002 we have done 187 lumbar and 48 cervical with no complications.

Discography is also performed in the hospital setting as an outpatient procedure. On a regular basis we have to turn away from 2 ? 5 Medicare patients per month. These patients end up either not having this vital diagnostic procedure done, or have it done in a more costly hospital setting.

On July 1, 2004 the CPT code 62287 (Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method) was placed on the CMS ambulatory surgery center approved procedures list. This procedure is similar in nature to discography. In both procedures the physician places a needle into the intervertebral disc while the patient is under conscious sedation. Our protocol is to perform the discography as a diagnostic tool. If it is then indicated the patient will have the disc aspiration (62287) procedure to remove disc material, which decreases the size of a herniation. Once the disc herniation is decreased, nerves that have been affected by the pressure from the herniation are no longer irritated and pain subsides. Since January 2002 we have performed 125 discography procedures in our surgery center with no complications.

It would make logical sense for CMS to approve discography (a diagnostic procedure) for the ASC setting since they have approved the disc aspiration (62287) procedure to remove disc material (a minimally invasive treatment) especially considering both procedures utilize similar methods to access the patients intervertebral disc space. We have had a significant success rate with this protocol, with positive patient outcomes. It has been a shame that we have not been able to offer this effective treatment option to Medicare patients.

Issues

Proposed Additions to the list of ASC covered procedures.

62290
62291

Submitter : **Date: 01/20/2005**

Organization : **Pinellas Bayside Surgical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Mr. TERRY BOHLKE** **Date: 01/20/2005**

Organization : **UNIVERSITY SURGERY CENTER**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-91-Attach-1.DOC

Submitter : Patricia Carroll-Chen, M.D. **Date:** 01/20/2005

Organization : Skin Cancer Treatment Center, P.C.

Category : Physician

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

See Attachment

CMS-1478-P-92-Attach-1.DOC

Submitter : Eric Ruud **Date:** 01/20/2005

Organization : Yakima Urology Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

Please re-evaluate the ASC payment level for CPT code 57288. The cost of the materials used in this procedure exceeds the proposed ASC group level reimbursement. We purchase the material for this procedure at an invoice price of between $850 and $950.

Proposed Deletions from the list of ASC covered procedures.

I?m writing to urge CMS to reconsider deletion of CPT codes 52000, 52281 and 55700 from the ASC list of approved procedures.

Having the option to be able to continue to perform these procedures in an Ambulatory Surgery Outpatient setting, I believe, is critical for maintaining patient access to an environment of higher quality of care when compared to a physician office/clinic setting. Quality management, performance improvement and infection control programs function in an ASC to insure that the best environment for the health and safety of the patient can be maintained at all times. These types of programs and not mandated for a physician?s office. There are studies that show a 10 times higher complication rate for similar procedures that are performed in a Clinic versus an ASC.

Being able to perform these procedures in an ASC allows the physician to greatly improve his efficiency in the way he/she practice medicine. This improved efficiency allows the physician to see more patients and see a patient less often due to being able to perform multiple procedures without repeated visits. The ASC?s highly trained nursing staff, the availability of necessary specialized instruments, and an environment where IV sedation can be administered safely allows the physician many options in the same visit when treating his/her patients. Ultimately the patient has better access due to the physician being more available for appointments, surgeries or procedures.

My recommendation to you would be that rather then eliminating these codes from the ASC approved list, you should developing a new payment mechanism to better reimburse for associated costs that correspond to these procedures.

Whether these urology based procedures be performed in a clinic or hospital or ASC, I believe the complete elimination of them will greatly impact what we as ASC can provide in the delivery of patient care environment; a high quality efficient low cost alternative to hospital outpatient departments and a safer more efficient means to deliver this care than in a clinic.

Thank you for your consideration,

Submitter : **Dr. W. Jack Lovern** **Date: 01/21/2005**

Organization : **Yakima Urology Associates**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Against Deleting 52000, 52281 and 55700

CMS-1478-P-94-Attach-1.DOC

CMS-1478-P-94-Attach-1.DOC

Submitter : **Dr. Frank Melograna** **Date: 01/21/2005**

Organization : **Willis/Melograna, MD, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1478-P-95-Attach-1.DOC

Submitter : **Date: 01/21/2005**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1478-P-96-Attach-1.DOC

Submitter : **Dr. Winston Mcgill** **Date: 01/21/2005**

Organization : **Dr. Winston Mcgill**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Ladies and Gentleman:

I am a practicing, board certified urologist, and I think it would be mistake for CMS to remove the cystoscopy codes 52000 and 52281, and the prostate biopsy code 55700 from the list of procedures for which an ambulatory surgery center facility fee will be paid. For a variety of reasons, an ASC is the best setting for these procedures. Many of our older, Medicare beneficiaries have multiple medical problems and require a higher level of care than is routinely available in a doctor?s office. Sedation or anesthesia can be more appropriately provided, and the resuscitation equipment and drugs are more abundant and accessible in the ASC over the office setting. It also saves the patient the physical and emotional ordeal of a hospital outpatient admission, as well as saving the patient exposure to the sicker patient population found in a hospital setting. It is also less expensive in an ASC over a hospital procedure.

While your data shows that physicians frequently do these procedures in their offices, surely this just reflects the fact that an ASC is not an option for many of us. Putting all financial considerations aside and considering only the interests of our patients, ASC settings will allow patients to receive more appropriate care and have better outcomes.

While using Medicare program dollars efficiently is very important, it should not be done in a way that wipes out a significant clinical option, such as the ambulatory surgery center setting for cystoscopy and prostate biopsy. CMS?s formulaic system for removing procedures from the ambulatory surgery center nips a valuable clinical tool in the bud. Instead of taking these procedures off the list now, CMS should work to set appropriate facility fees, and look at practice patterns in a few years, after more of the medical community has had an opportunity to learn the benefits of the ASC setting for their patient population who are sick or fragile enough to benefit from the ASC setting, but do not need to go to a hospital for an outpatient procedure.

Thank you for your consideration.

Yours truly,

Winston McGill, Jr. M.D.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000,52281, 55700

Submitter : **Mr. Peter Pavarini** **Date: 01/21/2005**

Organization : **Ocean Specialty Surgicenters, LLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1478-P-98-Attach-1.PDF

Submitter : **Dr. Alejandro Rodriguez** **Date: 01/21/2005**

Organization : **Central Maryland Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1478-P-99-Attach-1.DOC

Submitter : Frank Nezu **Date:** 01/21/2005

Organization : Central Maryland Urology Associates

Category : Physician

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

To whom it may concern,

I am writing to voice my opposition to the removal of codes for cystoscopy, cystoscopy/dilation, and To prostate biopsy from the CMS ASC procedure list.

I trained in Philadelphia at Thomas Jefferson University Hospital with extensive training in laparoscopy and minimally invasive surgery. This type of training is very sought after throughout the United States. I had received dozens of job offers prior to accepting an offer in Maryland. The reason I took the job with Central Maryland Urology Associates was I felt that they offered state of the art care. Two of the things that attracted me to the practice were the surgery center and their use of an electronic medical record system.

I feel that it is important to perform these procedures in a surgery center. Having a trained nurse monitoring the patient through these procedures is very important. Having an assistant dedicated to helping you set up and perform these procedures enables the physician to perform them with greater speed and safety. In Philadelphia we used IV sedation far more often that I do now in Maryland. After 6 months of practice I have not used IV sedation on any of these procedures.

I have left my family and friends in Philadelphia to start a new life here in Maryland as I feel it is a better state to practice medicine. Removing these procedures from our surgery center and the negative effect it would have on our practice would make me strongly reconsider that decision.

Whenever I am not sure of a decision to make in clinical practice I go back to the basics and think of how I would like to be treated. I would encourage anyone involved in making this decision to do the same. Ask yourself this: if I were to have a scope placed into my bladder would I want it done under the most sterile conditions? If I were to have a probe placed in my rectum and 12 core biopsies removed from my prostate would I want it done as quickly and safely as possible? Most of these procedures are performed to diagnose cancer. Would I not want the best conditions possible to help me, my father, mother, or sibling through such an ordeal?

Sincerely

Frank Nezu MD

Submitter : **Dr. perry sutaria** **Date: 01/21/2005**

Organization : **Dr. perry sutaria**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

Ladies and Gentleman:

I am a practicing, board certified urologist, and I think it would be mistake for CMS to remove the cystoscopy codes 52000 and 52281, and the prostate biopsy code 55700 from the list of procedures for which an ambulatory surgery center facility fee will be paid. For a variety of reasons, an ASC is the best setting for these procedures. Many of our older, Medicare beneficiaries have multiple medical problems and require a higher level of care than is routinely available in a doctor?s office. Sedation or anesthesia can be more appropriately provided, and the resuscitation equipment and drugs are more abundant and accessible in the ASC over the office setting. It also saves the patient the physical and emotional ordeal of a hospital outpatient admission, as well as saving the patient exposure to the sicker patient population found in a hospital setting. It is also less expensive in an ASC over a hospital procedure.

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Thank you for your consideration.

Yours truly,

Perry M. Sutaria, MD, FACS

Submitter : **Dr. David Chaikin** **Date: 01/21/2005**

Organization : **MorristownUrology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

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Thank you for your consideration.

Yours truly,

David Chaikin, MD

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

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Thank you for your consideration.

Yours truly,

David Chaikin, MD

Submitter : **Dr. Daniel Arrison** **Date: 01/21/2005**

Organization : **Maryland Urology Associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Cystoscopy with or without dilation and TRUS biopsy of prostate.
While many cystos, esp in women, are often uncomplicated, they still frequently require anesthesia and may require more invasive techniques than should be safely done in an office setting. This is particulaly true in prostate biopsies where the extra equipment (ultrasound), and occasional need for sedation and/or general anesthesia would make these very difficult if not unsafe in an office setting. I would therefore recommend not removing these procedures from the list of ASC procedures.

Submitter : **Dr. Emil Bisaccia** **Date: 01/21/2005**

Organization : **Affiliated Ambulatory Surgery, P.C.**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Affiliated Ambulatory Surgery, P.A.
182 South Street
Suite #1
Morristown, New Jersey 07960
973-267-0577

January 21, 2005

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1478-P
P.O. Box 8013
Baltimore, MD 21244-8013

To Whom It May Concern:

It is apparent that CMS is not aware of the movement by multiple state medical boards to limit the surgical procedures, especially reconstructive closures performed in physician?s offices. This is based on the inability to follow the patient safety issues such as complications and infection rates, which are not required to be reported and a serious array of problems, including death, which have occurred from office-based procedures. The elimination of the Ambulatory Surgery Codes for these procedures leaves those patients at risk for these complications where physicians without appropriate training perform these procedures without any credentialing at an Ambulatory Surgery Center (ASC) or a hospital.

Office environments have no standards for staff training in CPR, no rescue equipment available, and no Hospital Transfer Agreement in place. On the other hand, ASC?s are inspected for appropriate training and credentialing along with their detailed policies and procedures for each procedure done, and all complications are detailed and reported. In addition, if CMS is to reimburse these procedures done in a hospital setting, the cost will be dramatically higher while the patient, especially the elderly, will be exposed to the hospital setting of waiting for O.R. time as well as the attendant issues of scheduling. While the state medical boards are limiting the extent of flaps and grafts being performed in the office setting, CMS is encouraging large and complex advancement flaps to be performed in an office setting. If the state medical boards prohibit such procedures from being performed, the physician and more importantly the patient are left out of the loop. Such poorly considered policies should be reviewed and the patient must be considered before the OIG accountants.

Several other key points need to be considered. The damage to small businesses, a category into which most ASC?s fall, will cause the failure of these facilities and therefore effect a dramatic increase in health care costs, eliminating the competition between hospitals and ASC?s. That CMS could suddenly and drastically eliminate an entire category of reimbursement codes without some sort of advisory or phase-out period amounts to restricting trade in favor of one system ? the hospital. The fact that these codes would remain reimbursable in the hospital setting is a clear and unjust display of favoritism to the hospital industry and hospital-based specialties.

CMS encouraged physicians to develop ASC?s as centers of excellence for cost-effective care. Now that such centers have been developed and the expenditures made, this policy can essentially close centers which have been focused on patients and attendant to their needs, The scheme of reimbursement to hospitals but not to ASC?s can only serve to drive up overall costs and limit care for patients.

Emil Bisaccia, M.D., FACP
Professor of Clinical Dermatology
Columbia University
College of Physicians and Surgeons
New York, New York

Submitter : **Dr. Sean Egan** **Date: 01/21/2005**

Organization : **Dr. Sean Egan**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

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Thank you for your consideration.

Yours truly,

Sean C. Egan, MD

Submitter : **Dr. James Wendt** **Date: 01/21/2005**

Organization : **AUA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I would like to let you know that I am apposed to the deletion of cystoscopy and prostate biopsy reimbursement done at ASCs. We try to do as many as we can at our office, but there are situations when they have to be done at an ASC such as when the patient needs more physical assistance then we can provide or the patient is unable to cooperate. It is less expensive to have these done at an ASC then at a hospital. Also, an ASC is much more efficient at outpatient proceedures than a hospital, which the patient and patient's family appreciates. To eliminate these proceedures makes no sense financially or practically.

Submitter : **Dr. Patrick N Ciccone MD** **Date: 01/21/2005**

Organization : **Urology Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

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Thank you for your consideration.

Yours truly,

Urology Consultants
Patrick N Ciccone MD
Erol Ulker MD
Anthony DelGaizo MD
Micheal Ciccone MD

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
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Thank you for your consideration.

Yours truly,

Urology Consultants
Patrick N Ciccone MD
Erol Ulker MD
Anthony DelGaizo MD
Micheal Ciccone MD

Submitter : **Dr. Michael Barkoukis** **Date: 01/21/2005**

Organization : **Southwest Urology, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1478-P-108-Attach-1.DOC

Submitter : **Dr. Michael Berte** **Date: 01/21/2005**

Organization : **Southwest Urology, Inc.**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

"see Attachment"

CMS-1478-P-109-Attach-1.DOC

Submitter : **Dr. gene rosenberg** **Date: 01/21/2005**

Organization : **stone center of nj**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

Please continue coverage of cpt#52000 , rigid cystoscopy with or without dilation of the urethra. It requires some anesthesia and is quite painful with topical measures only.

Submitter : **Dr. David Bjorkman** **Date: 01/21/2005**

Organization : **American Society for Gastrointestinal Endoscopy**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Issues

Proposed Additions to the list of ASC covered procedures.

Please see the attached comment letter.

CMS-1478-P-111-Attach-1.DOC

CMS-1478-P-111-Attach-1.DOC

Submitter : **Dr. Konstantin Walmsley** **Date: 01/21/2005**

Organization : **Montclair Urological Group, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached comments on CMS Proposed Regulations - File Code CMS-1478-P, PROPOSED DELETIONS.

CMS-1478-P-112-Attach-1.DOC

Submitter : **Dr. Joseph Steinberg** **Date: 01/21/2005**

Organization : **Adult and Pediatric Urology Group**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

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Thank you for your consideration.

Yours truly,

Joseph Steinberg, MD FACS

Submitter : **Dr. Marc Greenstein** **Date: 01/21/2005**

Organization : **Dr. Marc Greenstein**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration.

Yours truly,

Marc Greenstein, DO
16 Pocono Road, Suite 114
Denville, NJ 07834

Submitter : **Date: 01/21/2005**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

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Thank you for your consideration.

Yours truly,

Alexander C. Gellman, MD
16 Pocono Road, Suite 114
Denville, NJ 07834

Submitter : **Dr. Marc Lowe** **Date: 01/21/2005**

Organization : **Group Health Cooperative**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Department of Health and Human Services
Attn: CMS ? 1478 ? P
PO Box 8013
Baltimore, MD 21244-8013

RE: CMS-1478-P code deletion PROPOSED DELETIONS

Dear Sirs:

I am writing to comment against the deletion of codes 52000 (Cystoscopy) 55700 (Prostatic needle Biopsy) and 52281 (Cystoscopy with urethral dilation) from the list of approved Ambulatory Surgery Center procedures. While cost containment is a laudable goal, the deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to Patient health and safety. Let me explain:

52000 (Cystoscopy): Cystoscopy is an often complex, painful procedure that, while often performed in a physician?s office, frequently requires the more advanced capabilities of an ASC. It is beyond the expertise of an office setting to provide the oft required sedation and post sedation monitoring for cystoscopy (see attachment 1, conscious sedation policy). Not only is it forbidden to administer such intravenous sedation in an office by many Medical Liability Policies, it is inherently unsafe.
It is not uncommon to do diagnostic cystoscopy only to find significant pathology that requires therapeutic intervention such as biopsy, resection, dilation, or other invasive treatment. In many cases that intervention can be addressed at the time of cystoscopy. The deletion of 52000 (cystoscopy) from the ASC list will be counterproductive by effectively requiring duplication of a similar but more complex service in an ASC after the diagnostic service is done in the office. In an era when efficiency and cost effectiveness is the goal, this deletion of 52000 (cystoscopy) is counterproductive and represents a threat to patient health and safety.

52281 (Cystoscopy with urethral dilation): Dilation of a stricture that requires cystoscopic guidance is a VERY painful and often VERY complex procedure requiring specialized equipment, dilators, personnel, as well as sedation and often full anesthesia. It does not necessarily require the hospital setting but does require the ASC setting in a large number of cases. It would be highly inappropriate to remove this code from the ASC approved list. It is simply not a procedure that can be done in an office setting routinely. Removing this option for management of urethral strictures would be a great disservice to patients and Urologist alike.

55700 (Prostatic needle Biopsy): Prostatic Biopsy, usually done in association with Transrectal ultrasound, now routinely includes 12-20 separate biopsies. It is uncomfortable and often includes intravenous sedation. It is unreasonable in today?s medical legal climate to expect Urologists to administer intravenous sedation without appropriate safeguards available only in an ASC or Hospital setting. Again, withdrawing this option is a disservice to Patients and Physician alike.

In conclusion, the decision to delete codes 52000, 52281, and 55700 is not supported by any Urologic organization and opposed by nearly every colleague I speak with. Removing these codes is counterproductive and removes options for efficient and cost effective humane management of many medical conditions. I urge you to reconsider and reinstitute 52000, 52281, and 55700 as ASC approved procedures.

Respectively submitted
Marc A. Lowe, MD

Submitter : **Dr. Kimberly Wood** **Date: 01/21/2005**

Organization : **HealthSouth**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Please accept the following attachments as comments from HealthSouth's Surgery Division on CMS-1478-P - Medicare Program; Update of Ambulatory Surgery Center List of Covered Procedures. One document is submitted in Microsoft Word format; an identical document is submitted in Adobe pdf format as a backup.

CMS-1478-P-117-Attach-2.PDF

CMS-1478-P-117-Attach-1.DOC

Submitter : **Dr. Roger Lubbers** **Date: 01/21/2005**

Organization : **Urological Group, Ltd.**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

It is high time that CMS awoke to the frequent abuse of performance of 52000, 52281, and 55700 in the ASC setting. Only rarely do these procedures need to be done under anesthesia, other than local. My group does literally hundreds of 52000 and 55700 per year in an office setting, and dozens of 52281 in the office setting. I cannot recall the last time I had to do a 52000 under general anesthesia.

Approximately 1% of my 55700 procedures require general or spinal anesthesia, and less than 1% of my 52281 procedures require it.

I think that eliminating these procedures from payment in the ASC setting will save an enormous amount of money with no decrease in quality of care rendered, and an increased inconvenience to only a handful of physicians and patients.

I commend CMS for arriving at this proposed regulation and urge CMS to look for other procedures currently being done, unnecessarily, in the ASC setting. Thank you for the opportunity to comment.

Submitter : **Dr. brian engebrecht** **Date: 01/21/2005**

Organization : **Dr. brian engebrecht**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

This is regarding the removal of 52000,52281,and 55700 from the ASC covered procedures. The vast majority of these procedures should be performed in an office setting to reduce the costs involved. In our area, those with an ownership interest in an ASC, perform virtually all of these procedures in the ASC setting, whereas those without a financial interest perform them in an office setting. Occasionally, these procedures are required to be done in an ASC, but the vast majority should not. Perhaps CMS should look at individual practice patterns and determine who is performing these in an ASC, and what financial incentives they have to do so.

Submitter : Dr. Robert Sher **Date:** 01/22/2005

Organization : Dr. Robert Sher

Category : Ambulatory Surgical Center

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Codes 52000,52281, 55700 SHOULD NOT be deleted from the ASC list. This is a patient safety issue. The office environment is inherently less safe than the ASC from a sterility and monitoring perspective. Cold soaking of instruments in an office setting puts the patient and personel at risk due to the toxic nature of these soaks. The absence of any regulatory oversight leads to an absence of quality control and assurance. An ASC is comparable in sterility to hospitals and an office setting puts patients at danger from a sterility and monitoring situation. Code 55700 (prostate biopsy) requires intra and post operative monitoring from both a hypotention and bleeding point of view. In our practice last year of 1200 prostate biopsies performed 75 patients had blood pressure issues and 4 patients had to be admitted to the hospital. Codes 55000 and 52281 can be painful especially to men. If done in an office setting this will often lead to a second procedure due to the need to a biopsy or fulgeration which cannot be done in an office setting. Patients with urologic abnormalies (i.e. prostate cancer, bladder cancer, strictures, previously operated or irradiated patients, ect.) are best served in a facility setting which provides a sterile environment, appropriate monitoring, the availability of anesthesia, and specially trained personnel. An office setting will pose a risk to the patient from a sterility and safety point of view. Site of service should be chosen based on patient need. Anatomical differences between men and women affect site of service choices, but CMS does not take this into account. Men, due to more pain and difficulty with cystoscopy often require intra and post operative monitoring which cannot be done in an office setting. DO NOT DELETE CODES 52000, 52281, 55700.

Submitter : **Dr. Winston McGill Jr.** **Date: 01/22/2005**

Organization : **Mid Essex Urology Associates**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-121-Attach-1.DOC

Submitter : **Mr. Steven Pimental** **Date: 01/22/2005**

Organization : **Same Day SurgiClinic**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1478-P-122-Attach-1.DOC

Submitter : **Dr. Raymond Andronaco** **Date: 01/22/2005**

Organization : **Dr. Raymond Andronaco**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1478-P-123-Attach-2.DOC

CMS-1478-P-123-Attach-1.DOC

Submitter : **Mr. RICHARD HITCHCOCK** **Date: 01/22/2005**

Organization : **ULTRASOUND TECHNICIAN**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

1/22/05

Issues

Proposed Deletions from the list of ASC covered procedures.

REGUARDING DELETION OF 55700 (SURGICAL FEE FOR PROSTATE BX) I BELIEVE IS WITHOUT COMPLETE UNDERSTANDING OF WHY THESE ARE DONE IN THE ASC TO BEGIN WITH. MOST PROSTATE BX'S CAN BE PREFORMED IN A DOCTORS OFFICE WITH THE USE OF A LIDOCAINE BLOCK, (WICH IS NOT REIMBURSABLE,AND THE UROLOGIST PROVIDES THIS FOR FREE). WITH THE MOST RECENT DATA SHOWING ANYWERE FROM 8 TO 12 PLUSE BX'S ARE NESSARY TO GET A COMPLETE SAMPLE OF THE PROSTATE. A TRANS RECTAL ULTRASOUND GUIDED BX 10-12++ SAMPLES WITH THE STANDARD 18 GUAGE NEEDLE IS TO MUCH FOR SOME PATIENTS. TO SIMPLY SAY ITS OKAY AT A HOSPITAL FACILITY 'OUT PT' AND NOT ASC , I DONT SEE THE SAVINGS. THE EFFICIENTCY IS MUCH BETTER AND THE COST ARE MUCH LOWER FOR EVERY ONE IN ASC. FOR A SIMPLE BX OF THE PROSTATE WITH A LITTLE ANESTESIA. GOING TO THE HOSP IS JUST TOO MUCH FOR SUCH A QUICK EASY PROCEDURE. AS A ULTRASOUND TECH I HAVE SEEN BOTH WAYS, HOSP AND ASC AND IT IS MUCH MORE COST EFFECTIVE FOR EVERY ONE INVOLVED AND MOST IMPORTANTLY EASIER ON THE PATIENTS. PLEASE CONSIDER THE FACT THAT THIS IS A TRANS RECTAL PROCEDURE WHERE BY THESE PATIENTS ARE PUT THROUGH ALOT TO BEGING WITH. BY ALLOWING THEM TO HAVE THIS DONE IN A ASC I BELIEVE IS BETTER FOR ALL PATIENTS.

Submitter : **Dr. Mark Miller** **Date: 01/23/2005**

Organization : **Consultants in Urology, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

Ladies and Gentleman:

I am a practicing, board certified urologist, and I think it would be mistake for CMS to remove the cystoscopy codes 52000 and 52281, and the prostate biopsy code 55700 from the list of procedures for which an ambulatory surgery center facility fee will be paid. For a variety of reasons, an ASC is the best setting for these procedures. Many of our older, Medicare beneficiaries have multiple medical problems and require a higher level of care than is routinely available in a doctor?s office. Sedation or anesthesia can be more appropriately provided, and the resuscitation equipment and drugs are more abundant and accessible in the ASC over the office setting. It also saves the patient the physical and emotional ordeal of a hospital outpatient admission, as well as saving the patient exposure to the sicker patient population found in a hospital setting. It is also less expensive in an ASC over a hospital procedure.

While your data shows that physicians frequently do these procedures in their offices, surely this just reflects the fact that an ASC is not an option for many of us. Putting all financial considerations aside and considering only the interests of our patients, ASC settings will allow patients to receive more appropriate care and have better outcomes.

While using Medicare program dollars efficiently is very important, it should not be done in a way that wipes out a significant clinical option, such as the ambulatory surgery center setting for cystoscopy and prostate biopsy. CMS?s formulaic system for removing procedures from the ambulatory surgery center nips a valuable clinical tool in the bud. Instead of taking these procedures off the list now, CMS should work to set appropriate facility fees, and look at practice patterns in a few years, after more of the medical community has had an opportunity to learn the benefits of the ASC setting for their patient population who are sick or fragile enough to benefit from the ASC setting, but do not need to go to a hospital for an outpatient procedure.

Thank you for your consideration.

Yours truly,

Mark I. Miller, M.D.

Issues

Proposed Additions to the list of ASC covered procedures.

Submitter : **Date: 01/23/2005**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I think it would be a mistake to delete the cystoscopy codes from the ASC list many of these pts are ill and can not have the procedure in the office, many are afraid as well. As for the sling procedure I feel it should be in category 9 as this is a high risk procedure

Submitter : **Dr. John Zitelli** **Date: 01/23/2005**

Organization : **Zitelli and Brodland PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1478-P-127-Attach-1.TXT

Submitter : **Mr. Richard Chang** **Date: 01/23/2005**

Organization : **Yakima Urology Associates, PLLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

January 23, 2005

Department of Health and Human Services
Attn: CMS ? 1478 ? P
PO Box 8013
Baltimore, MD 21244-8013

RE: CMS-1478-P PROPOSED DELETIONS

Issue: ASC Cost Efficiency

Dear Sirs:

I am writing to comment against the deletion of codes 52000 (Cystoscopy) 55700 (Prostatic needle Biopsy) and 52281 (Cystoscopy with urethral dilation) from the list of approved Ambulatory Surgery Center procedures.

The deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to patient health and safety. Each of these codes represents a procedure that while often performed in an office setting clearly need the advanced setting provided by an ASC in a significant percentage of cases.

I am a urology practice administrator in an underserved area. We have a high percentage of Medicare age patients and we depend on efficiency in our practice patterns to maintain adequate income to cover my ever increasing overhead in the face of decreasing reimbursement trends. One of the efficiencies we have in our practice is the use of an Ambulatory Surgery Center. The ASC is highly efficient, providing a safe and efficient alternative to the cumbersome slow bureaucracy of the hospital. The additional time burden of transferring these ASC cases to the hospital will effectively reduce my availability to care for other patients and ultimately create an access problem. Time and efficiency are our only tools to fight the trend of reduced reimbursements. To administratively remove a cost and time effective alternative to the hospital to do these procedures is threat not only to the health, safety, and access of our Medicare patients but to the health and safety of our medical practice.

I urge you to reconsider your decision and keep codes 52000 (cystoscopy), 52281 (cystoscopy with urethral dilation), and 55700 (prostate biopsy) on the Ambulatory Surgery Center Procedure list.

Respectively submitted

Richard M. Chang, Administrator
Yakima Urology Associates, PLLC
111 S 11th Ave Ste 120
Yakima WA 98902
509 249 3900
rchang@yua.com

CMS-1478-P-128-Attach-1.DOC

Submitter : **Ms. Phyllis Avery** **Date: 01/24/2005**

Organization : **Avery Law Offices, PLLC**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment for comment regarding the requested addition of codes 64416, 64446, 64448 and 64449.

CMS-1478-P-129-Attach-1.WPD

Submitter : **Dr. Robert May** **Date: 01/24/2005**

Organization : **Dr. Robert May**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Dear Sirs:

The January 2003 report from the HHS Office of Inspector General proposed the deletion of several urologic codes from the ASC covered procedures list.

These included:
51710 - change of bladder tube
51726 - complex cystometrogram
51772 - urethra pressure profile
52285 - cystoscopy and treatment
52000 - Cystourethroscopy (separate procedure)
52281 - Cystourethroscopy with calibration and/or dilation ...
55700 - prostate biopsy.

CMS' medical advisors have already determined that 51710, 51726 and 51772 should remain on the list for health and safety reasons. I would like you to consider leaving all of these codes for this same reason. Ambulatory surgery centers are able to provide more extensive services than a typical physicians office, including sedation or anesthesia, on site flouroscopy, better aseptic conditions and the opportunity to treat pathology which is found without an entirely separate procedure.

I suggest that the three codes which remain under consideration for deletion from the list are, in fact, more likely to need these advanced services than the four which were removed from this consideration. Cystoscopy, urethral dilation, and prostate biopsies can be performed in the office setting on some patitients, but there are always patients with special needs who are best served by a higher level of care than can be provided in the office. This may be due to comorbid conditions, pain tolerance or anxiety. By removing these codes from the list, these patients will be forced into hospital outpatient surgery facilities, thus increasing the expense for CMS, inconvenience for our patients, and cost of delivering care for providers.

I appreciate this opportunity to comment on these changes, and I strongly urge you to leave the decision as to the most appropriate location for a procedure to be performed in the hands of the specific patients and physicians involved. Although there are some areas where generalities can be made and costs cut without loss of quality, I do not think this is one of them. If I can answer any questions you may have, my office number is (361) 884-6381.

With Regards,

Robert A. May, Jr., M.D.

Submitter : **Dr. Joohyong Kim** **Date: 01/24/2005**

Organization : **Outpatient Urology Center of Dover**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I strongly oppose the deletion of CPT codes 5200, 52281, and 55700 from the Medicare ASC list of covered services. Having been in practice as a board certified urologist in Dover, Delaware for eight years, I am quite concerned about these proposed changes. CMS should not delete these CPT codes for numerous reasons.

First, these procedures are performed on patients with specific urologic conditons which are best handled in an environment that provides a sterile setting, appropriate cardiovascular monitoring, ready access to anethesia services, and staffing specifically trained to handle both medical and surgical emergencies. In comparison to an office based setting, our ASC provides the sterile working environment that's crucial for the well being of the patient.

Secondly, I believe that the deletion of these procedures from the ASC setting will not result in any significant reduction in cost. In fact, I believe the Federal goverment will shell out more money in the long run. Instead of shifting these procedures to the office setting, the majority of them will return to the hospital setting where considerably higher cost will be incurred. The quality of care provided in the office setting, when performing the above mentioned procedure, will suffer immensely when compared to the ASC setting. Offices can not provide a dedicated sterile operating room environment, the capability of providing IV sedation/ansethesia, and cardiovascular and pulmonary monitoring in the post operative period. Furthermore, patients will be burdened by higher copays when these procedures return to the hospital setting.

Thirdly, it is not uncommon to detect an unexpected problem when performing a diagnostic cystoscopy procedure. For instance, if I discover a small bladder calculus, I am in a situation to remove that stone in the ASC setting. On the other hand, if that cystoscopy had been performed in the office setting, I would not have had the equipment to handle that situation. Instead, I would need to schedule that patient at a later date in the hospital setting which increases overall costs across the board.

Overall, the ASC is the most efficient, safe, and economic setting to perform the majority of the proposed deleted procedures. It provides easier access for the patient to these procedures and more flexible scheduling. The quality of care and high level of patient ssafety cannot be matched in the office setting. We as physicians, along with the patients, should be able to determine the appropriate site of service based on clinical reasons and not mere financial motives. Hopefully, my comments will help convince the CMS to reconsider the proposed deletions of CPT codes 52000, 52281, and 55700 from ASC covered services.

Sincerely yours,

Joohyong H. Kim, M.D.

Submitter : **Dr. john spirnak** **Date: 01/24/2005**

Organization : **urology northern ohio**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Surgeons must continue to be allowed to do their surgical procedures where they feel their patients will receive the best care. Many times it is necessary to do procedures in a more controlled setting than a Drs. office, hence urologists need the ability to sched. their cases where they feel their pts will receive the best care. Surgery centers provede such an environment. Additionally the cost of doing a procedure in a free standing surgery center is more cost effective than doing the similar procedure in a hospital setting.

Submitter : **Dr. Kimberly Wood** **Date: 01/24/2005**

Organization : **HealthSouth**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Please accept the following attachments as comments from HealthSouth's Surgery Division on CMS-1478-P - Medicare Program; Update of Ambulatory Surgery Center List of Covered Procedures. Please accept these as updates of our prior submissions on 1/21/05, Temporary Comment Number 12896. The prior comments were not submitted on letterhead and we apologize for the error. Please find two documents attached. One document is submitted in Microsoft Word format; an identical document is submitted in Adobe pdf format as a backup.

CMS-1478-P-133-Attach-2.PDF

CMS-1478-P-133-Attach-1.DOC

Submitter : **Mr. Kevin McMahon** **Date: 01/24/2005**

Organization : **The Jackson Clinic, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

See Attachment

CMS-1478-P-134-Attach-1.DOC

CMS-1478-P-134-Attach-1.DOC

Submitter : **Dr. W. Jack Lovern** **Date: 01/24/2005**

Organization : **Yakima Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Against deleting 52000, 52281 and 55700

CMS-1478-P-135-Attach-1.DOC

CMS-1478-P-135-Attach-1.DOC

Submitter : **Dr. Joseph Williams** **Date: 01/24/2005**

Organization : **Boise Urology, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs:

Please read the atttached letter. Thank you.

Sicerely,

Joseph H. Williams,M.D.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000
52281
55700

CMS-1478-P-136-Attach-1.DOC

CMS-1478-P-136-Attach-1.DOC

Submitter : **Mr. Leonard Warren** **Date: 01/24/2005**

Organization : **UroTech**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

CMS should clarify which CPT Code the GreenLight laser (for treatment of BPH) deserves-- either 52647 or 52648 and then, reimburse for it accordingly.

While they are currently grouped as a Group 9 (national average Medicare payment of $1,339), there is no accounting or recognition of the fiber's costing $700 -- $1,000; thereby, making the procedure unprofitable in an ASC-setting and dictating that the procedure be performed in the HOPD at $3,750.

Urologists would agree that the appropriate site-of-service is an ambulatory surgery center. By reimbursing for the laser fiber (similar to CMS' reimbursing for an IOL for cataract extractions), CMS would encourage and shift the GreenLight laser to the appropriate setting.

In doing so, CMS would not only add convenience to the patients and physicians but generate cost savings-- a win-win-win.

Issues

Proposed Additions to the list of ASC covered procedures.

Proposal to reimburse appropriately for GreenLight PVP laser procedures:

52647 Non-contact laser coagulation of prostate, including control of postoperative bleeding

52648 Contact laser vaporization with or without transurethral resection of prostate, including control of postoperative bleeding

Submitter : **Dr. mark bowles** **Date: 01/24/2005**

Organization : **tennessee urology associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

these deletions should be repealed as they will cause difficulties with access to care in the approiate setting [asc].This may lead to exposure of noninfected patients to sicker and infected patients in the hospital.Moving these patients with uncomplicated surgeries to hospitals will further stress the the delivery of care for sicker patients.

Submitter : **Dr. Herbert Riemenschneider** **Date: 01/24/2005**

Organization : **Riverside Urology, Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : **Dr. Jonathan Agins** **Date: 01/24/2005**

Organization : **Dr. Jonathan Agins**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am respectfully asking you to reconsider these deletions. If you have ever had a rigid cystoscopy, urethral dilation, or prostate biopsy, you would understand my concerns. Deleting these codes would NOT funnel these procedures to the office, as you presumably are hoping; we would simply do them in the hospital. This is inconvenient to the patient and more expensive to Medicare. Forcing a Surgeon to do these procedures in the office, without anesthesia or the sterility that an ASC offers, would put the patient at an unreasonable risk and impair our ability to diagnose and treat prostate, bladder, kidney, and urethral cancer. Thank you for your time and anticipated understanding.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000,52281,55700

Submitter : **Dr. John Siegal** **Date: 01/24/2005**

Organization : **Dr. John Siegal**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Deleting these codes would put patients at an unreasonable risk for infection, pain, and missed diagnoses. By forcing these procedures into the office, you are unfairly jeopardizing our patients and unfairly exposing us to liability. Medicare will lose money by forcing us to do these procedures in the less efficient and more costly hospital setting. An ASC allows us to offer the patient the standard of care in 2005 and saves Medicare money.

Issues

Proposed Deletions from the list of ASC covered procedures.

52000,52281,55700

Submitter : **Dr. W. Jack Lovern** **Date: 01/24/2005**

Organization : **Yakima Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Against deleting 52000, 52281 and 55700

CMS-1478-P-142-Attach-1.TXT

CMS-1478-P-142-Attach-1.TXT

Submitter : **Dr. herbert riemenschneider** **Date: 01/24/2005**

Organization : **RUI**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : **Dr. W. Jack Lovern** **Date: 01/24/2005**

Organization : **Yakima Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Against deleting 52000,52281 and 55700

CMS-1478-P-144-Attach-1.DOC

CMS-1478-P-144-Attach-1.DOC

Submitter : **Dr. michael James** **Date: 01/24/2005**

Organization : **Mankato Clinic**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Dear Sirs,

Please do not delete 52000, 52281 and 55700 from the list of covered services. We must be able to do these procedures with the help of anesthsia for many of our seniors and disabled patients. If we cannot do it at an ASC we will be forced to do it in the hospital which is more expensive and much less conveinient

M James

Submitter : **Dr. MARK PECKLER** **Date: 01/24/2005**

Organization : **UROLOGY ASSOCIATES, LTD., P.S.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs:

I am writing to comment against the deletion of codes 52000 (cystoscopy), 55700 (Prostatic needle Biopsy) and 52281 (Cystoscopy with urethral dilation) from the list of approved Ambulatory Surgery Center procedures.

The deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to patient health and safety. Each of these codes represents a procedure that while often performed in an office setting clearly need the advanced setting provided by an ASC in a significant percentage of cases. To administratively remove a cost and time effective alternative to the hospital to do these procedures is a violation of our fiduciary responsibility to our Medicare patients.

"The American people deserve a regulatory system that works for them, not against them: a regulatory system that protects and improves their health, safety, environment, and well-being and improves the performance of the economy without imposing unacceptable or unreasonable costs on society; regulatory policies that recognize that the priate sector and private markets are the best engine for economic growth; regulatory approaches that respsect the role of State, local, and tribal governments; and regulations that are effective, consistent, sensible, and understandable."

The elimination of these ASC codes mentioned above threatens the health and safety of Medicare Patients who deserve access to reasonable and cost effective medical servicess. I urge you to reconsider your decision and keep codes, 52000 (cystoscopy), 52281 (cystoscopy with urethral dilation, and 55700 (prostate biopsy on the Ambulatory Surgery Center Procedure list.

Rerspectively submitted,

Mark S. Peckler, M.D.
David M. Ward, M.D.
Mary P. Bowman, Office Manager

Issues

Proposed Deletions from the list of ASC covered procedures.

RE: CMS-1478-P PROPOSED DELETIONS

Submitter : **Date: 01/24/2005**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Comments on Proposed Regulations of Centers for Medicare and Medicaid Services
File Code: CMS-1478-P
Issue Identifier: PROPOSED DELETIONS

Ladies and Gentleman:

I am a practicing, board certified urologist, and I think it would be mistake for CMS to remove the cystoscopy codes 52000 and 52281, and the prostate biopsy code 55700 from the list of procedures for which an ambulatory surgery center facility fee will be paid. For a variety of reasons, an ASC is the best setting for these procedures. Many of our older, Medicare beneficiaries have multiple medical problems and require a higher level of care than is routinely available in a doctor?s office. Sedation or anesthesia can be more appropriately provided, and the resuscitation equipment and drugs are more abundant and accessible in the ASC over the office setting. It also saves the patient the physical and emotional ordeal of a hospital outpatient admission, as well as saving the patient exposure to the sicker patient population found in a hospital setting. It is also less expensive in an ASC over a hospital procedure.

While your data shows that physicians frequently do these procedures in their offices, surely this just reflects the fact that an ASC is not an option for many of us. Putting all financial considerations aside and considering only the interests of our patients, ASC settings will allow patients to receive more appropriate care and have better outcomes.

While using Medicare program dollars efficiently is very important, it should not be done in a way that wipes out a significant clinical option, such as the ambulatory surgery center setting for cystoscopy and prostate biopsy. CMS?s formulaic system for removing procedures from the ambulatory surgery center nips a valuable clinical tool in the bud. Instead of taking these procedures off the list now, CMS should work to set appropriate facility fees, and look at practice patterns in a few years, after more of the medical community has had an opportunity to learn the benefits of the ASC setting for their patient population who are sick or fragile enough to benefit from the ASC setting, but do not need to go to a hospital for an outpatient procedure.

Thank you for your consideration.

Yours truly,

Safwat M. Awad M.D. F.A.C.S.

Submitter : **Dr. daniel nevarre** **Date: 01/24/2005**

Organization : **plastic surgical associates of johnstown, inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Greetings, I am writing to halt the addition and or deletion of codes for adjacent tissue transfer (14000 through 14061) wound dehiscence (12021) , excision of malignant skin lesions (11600 - 11646) and complex closures 13101 - 13152). Each of these situations is patient and disease dependent. Oft times, we do a small tissue transfer in a nonsensitive and nonpainful area in the office. Similarly, sometimes for the same code, we elect to use general anesthesia in a hospital if the patient has many comorbid diseases or if the area although small is very complex. For all the codes mentioned, this situation exists. Having someone dictate where each code should be done , in these cases, can be unsafe for the patient or can be an overutilization of services. We surgeons simply wish to do what is right for our patients and most efficiently uses the health care resources to get the job done. For these codes, this can only be done on a case by case basis made by the surgeon. Please call me (814)536-9000 as I would gladly come in person to draw pictures or present a case to you to emphasize these points.

Submitter : **Dr. Joel Borkow** **Date: 01/24/2005**

Organization : **Plastic Surgical Associates of Johnstown**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir: I am a Medicare Inspector, Surgeon, and Ambulatory Surgery Center Owner. I operate in three settings: office, surgery center, and hospital. Please do not dictate where I must perform codes 14000 -14061, 12021, 11600- 11646 and 13101-13152. The place where I perform each of these procedures depends mostly on patient safety. The place where the procedure is done depends on the clinical situation as well as the technical aspects of the procedure and on the patients overall health. dictating the location of where to perform these services should be left up to the surgeon who is responsible for the patients safety.

Submitter : **Date: 01/24/2005**

Organization : **East Mississippi Endoscopic Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Although, I am happy to see CMS is making an attempt to update the list every two years as required, I feel that some updates are based on out of date data that is not a current reliable indicator of cost savings to the Medicare program.

Issues

Proposed Deletions from the list of ASC covered procedures.

CMS should not delete CPT codes 52000, 52281 and 55700 because even though these procedures can be performed in an office, the patient's health condition may demand more extensive services. Using numeric site of service thresholds for deleting procedures is arbitrary and does not permit cost-effective individual patient consideration. In many cases, the physician would be forced to use a hospital setting which would ultimately cost CMS more and cost the patient more. The level of sterility in an ASC matches that of a hospital but do you think you could say the same for an office setting? Most offices do not have the equipment, personnel or space to maintain the sterility required of a cystoscopy procedure. I do not beleive that CMS should assume that deleting these codes will save money based on the rationale that the procedures will migrate to a less expensive office setting when most physician offices will not want to assume these costs. They will send the patients to the more costly hospital setting.

Submitter : **Mr. david nevarre** **Date: 01/24/2005**

Organization : **plasticsurgical associates of johnstown**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

Kind Sir or Madam: The purpose of this missive is to request that deletions of codes (14000-14061, 12021, 11604 - 11644, 13101 - 13152) from the ASC list be halted. Our physicians see patients and perform these procedures at one of three settings (hospital, office, or ASC) depending on the individual patient's clinical situation and health, and where the procedure can be done most safely and efficiently. Dictation where these should be done fails to recognize the differences between patient' s, clinical presentation, and capabilities of facilities. This is best left up to the surgeon.

Submitter : **Mrs. Bonnie Shannon** **Date: 01/24/2005**

Organization : **plastic surgical associates**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I work as a nurse for an ambulatory surgery facility, and am writing to ask that you do not dictate where certain codes (14000-14061, 12021, 11604-11644, 13101 -13152) be performed. I see these codes used for office, hospital , and ambulatory surgery center procedures. The surgeons determine where the procedure can be done most safely and efficiently. Restricting where these certain CPT codes can be performed wastes resources , and more importantly jepordizes patient safety.

Submitter : **Ms. Carole Shirk RN** **Date: 01/24/2005**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on the proposed deletion of CPT codes 52000, 52281 and 55700.

CMS-1478-P-153-Attach-1.DOC

CMS-1478-P-153-Attach-1.DOC

Submitter : **Dr. Joseph Murphy** **Date: 01/24/2005**

Organization : **Urologic Surgery Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issues

Proposed Additions to the list of ASC covered procedures.

Proposed Deletions from the list of ASC covered procedures.

see attached

CMS-1478-P-154-Attach-1.DOC

CMS-1478-P-154-Attach-1.DOC

CMS-1478-P-154-Attach-1.DOC

Submitter : **Dr. Demetrios Simopoulos** **Date: 01/24/2005**

Organization : **Dr. Demetrios Simopoulos**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my opposition to plans by CMS to limit services that Medicare recipients can receive at Ambulatory Care Surgery Centers.

Medicare patients deserve the same access to health care that all members of the community enjoy. Ambulatory Care Surgical centers provide efficient and quality care to all patients. To deny the elderly these services represents limiting access to quality care and essentially establishes a two-tier medical delivery system: one system that treats private patients, and another system, hospital based and more costly, that treats Medicare patients.

In my community, a patient will be charged considerably more if his or her urologic procedure is performed at the hospital in comparison to an Ambulatory Care Surgical Center.

Specifically, at issue, are the plans by CMS to deny facility payment for Medicare recipients who undergo Cystoscopy, Cystoscopy and Urethral Dilation, and Prostate Biopsy at an Ambulatory Surgical Center.

It is my experience as an urologist that there are patients who definitely require these procedures with anesthesia in an Ambulatory Surgical Center. Most specifically, I have some male patients with complex urethral stricture disease who we have attempted to perform dilation on in the office and who cannot tolerate the procedure in the office because of significant pain. These patients benefit significantly from having the procedure performed in the ASC setting. My point in this regard is as follows: I do not think it is fair to generalize the needs of Medicare patients and deny Medicare patients the option of being treated at an ASC if they will benefit from that treatment.

Additionally, there are a number of other reasons why I would not favor this change in CMS policy. First, I often find it difficult to schedule out-patient procedures at the hospital. Often, the hospital is handling emergencies and major cases and do not give my patients who require out-patient treatment any priority on the operating room schedule. I might schedule a case at 11 AM at the hospital, but because of emergencies or other major cases, my patient will be delayed until 2 PM. However, at an Ambulatory Care Surgical Center, my patients receive priority and are treated in a timely fashion. Secondly, my patients are very concerned about their co-payments for medical care. It would be a hardship for many of them to pay the higher fees that the hospital charges when an Ambulatory Surgical Center charges much less.

I believe that if CMS denies payment to Ambulatory Surgical Centers for the above procedures, Medicare patients will no longer enjoy the same access and quality care that all other patients benefit from. I would urge you not to make these changes.

Thank you for the opportunity to make comments in this regard,

Demetrios N. Simopoulos, M.D.

Issues

Proposed Deletions from the list of ASC covered procedures.

Cystoscopy--52000
Cystoscopy and Urethral Dilation--52281
Prostate Biopsy--55700

Submitter : **Dr. Richard Levin** **Date: 01/24/2005**

Organization : **Urologic Surgery Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-156-Attach-1.DOC

Submitter : **Dr. Peter Filderman** **Date: 01/24/2005**

Organization : **Urologic Surgery Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1478-P-157-Attach-1.DOC

Submitter : **Date: 01/24/2005**

Organization : **Medical Group Management Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1478-P-158-Attach-1.DOC

Submitter : **Mrs. Jackie Cowan** **Date: 01/24/2005**

Organization : **Plastic Surgical Associates of Johnstown**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to request that changes to the ASC list of approved procedures not be modified in regards to codes 14000 - 14061, 12021, 11604-11644, 13101 - 13152. I have seen each of these procedures done safely in each setting of the office, surgery center, and hospital. The difference is in the patient as to where the procedure should be done. A complex closure on the arm may be done in the office, but if the patient is histrionic and the wound is extremely dirty, a surgery center would be more appropriate. Further, if the wound is extremely dirty or requires special equipment (dermatome) that may not be in a surgery center, then the patient would need to go to a hospital. My surgeons know the patient's the best and they know the capabilities and limitations of various facilities that they use. For the mentioned codes, determination of where the procedure can be done most safely is a decision that only the surgeon can make.

Submitter : **Dr. Emil Totonchi** **Date: 01/24/2005**

Organization : **Emil Totonchi M.D. F.R.C.S,S.C.**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

I would like to express my total disagreement with CMS proposal to delete 52000,52281,55700 from the list of approved ASC procedures.
I believe that this proposal is based solely on financial factors and ignoring the multiple aspects of patients condition and the care they require. The more important parameters that should be considered must include:
-Gender.
-Mental,Emotional and Physical status of the patient.
-Associated co-morbid conditions.
-Physcial Facilities including Physcian's office limitations.
-Need for General Anesthesia or I.V. sedation.
-Community variables and geographic access to care.
I believe such measures will not result in better care or lower cost.
I strongly recommend that CMS withdraw these proposals.

Thank You In Advance,

Emil Totonchi M.D. F.R.C.S,S.C.

Submitter : **Miss. Tina Rothgeb** **Date: 01/24/2005**

Organization : **plastic surgical associates of Johnstown**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Hello. I work as an office manager for a surgeons office and ambulatory surgery center. I perform billing for the surgeons that work in the office, in the surgery center, and in the hospital. The elimination of codes (14000-14061, 12021, 11604 -11644, 13101 - 13152) from the ASC list and dictating where they can be carried out would be a major safety issue for patients. For each of these codes, some are best done on the patient in the office, some in the hospital, and some in the ambulatory surgery center. We have billed each of these codes at each of the facilities. The surgeon decides where the procedure should be and can be done. This provides the safest and best care for each patient and their particular situation. Please do not hesitate to call if I can provide further assistance.

Submitter : **Mr. Charles I Busack** **Date: 01/24/2005**

Organization : **Berks Urologic Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Deletions from the list of ASC covered procedures.

Comments on the proposed deletion of CPT codes 52000, 52281 and 55700.

CMS-1478-P-162-Attach-1.DOC

CMS-1478-P-162-Attach-1.DOC

Submitter : **Dr. Barry Seidman** **Date: 01/24/2005**

Organization : **Dr. Barry Seidman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1478-P-163-Attach-3.PDF

CMS-1478-P-163-Attach-2.PDF

CMS-1478-P-163-Attach-1.TXT

Submitter : **Miss. Mary Ann Wells** **Date: 01/24/2005**

Organization : **Allegheny Anesthestists**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Good Day. I am aware of proposed legislation to limit where certain procedures (14000 - 14061, 13100 - 13152, 12021, 11604 - 11644) can be done. I work in numerous ambulatory surgery centers, hospitals, and see the same type of procedure done in each of these settings as well as in the office setting. Although the surgery done receives the same code, the setting is most often dictated by the medical condition of the patient, capabilities and equipment of the facility, and technical complexity of the procedure. Deleting these codes from being able to be performed at ASC's would result in restricting care and compromising patient safety along with the surgical result. The decision of where to perform these codes is best left to the surgeon.

Submitter : **Dr. Tracey Anne Culbertson** **Date: 01/24/2005**

Organization : **Cosmetic & Plastic Surgery of Frederick**

Category : **Individual**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Re: file code CMS-1478-P
PROPOSED DELETIONS
Medical Program; Update of Ambulatory Surgical Center (ASC) List of Covered Procedures; codes 13100, 13101, 13120, 13131, 13132, 13150, 13151

Please see attached memo.

CMS-1478-P-165-Attach-1.DOC

Submitter : **Dr. william mauch** **Date: 01/24/2005**

Organization : **Salina Urology Care Center, L.L.C.**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1478-P List of Proposed Deletions for Ambulatory Surgery Centers

Dear Sirs:

I am writing to you because of the proposal to delete cystoscopy (CPT-52000), and prostate biopsy (CPT-55700) from the list of ASC (list of approved Ambulatory Surgery Centers? procedures). I oppose the deletion of these codes from the Medicare ASC approved list and below outline the reasons for this opposition.

First, let me say that I believe that many cystoscopies and prostate biopsies can be safely performed in the office setting. However, I believe that the site of these procedures should be determined on an individual basis rather than by a blanket ruling that does not take into account individual patient factors. Certainly some patients should be treated in a facility that offers more than an office setting is able. These patients will necessarily have to be transferred not to the cheaper office setting, but rather to the more expensive hospital setting. This is likely to lead to both greater expense for CMS and also to less convenient care for the patients, especially here in rural America where substantial driving times may be required for return visits. Certainly, high risk patients and patients who require anesthesia for their procedure are examples of types of patients that would be better served by undergoing their procedure in an ambulatory surgery center.

Next I have just a brief comment on each of the proposed deletions. With regard to cystoscopy, many therapeutic procedures are preceded by a diagnostic cystoscopy and under the current reporting system, I believe that these are not reported to CMS, as they are not paid separately. Therefore I believe that CMS is unaware of the frequency with which this occurs. For example, a patient who has hematuria and a suspicious IVP, often will undergo diagnostic cystoscopy to confirm or refute the presence of a bladder tumor, and then undergo resection of that, or fulguration of that bladder tumor at the same ambulatory surgery center setting.

With regard to prostate biopsy, I would like to point out that the hospitals in our area do not have transrectal ultrasound and guided biopsy capabilities in the operating room. This will cause a decline in the quality of care if patients who require prostate biopsy in a hospital undergo this biopsy without ultrasound guidance. In addition, some patients who have co-existing, primarily rectal, diseases, cannot as a practical matter, be biopsied in the office. Typically because these patients require anesthesia for both safety and comfort.

In summary, the ambulatory surgery center provides a realistic alternative to the hospital out-patient operating room setting for both cystoscopy (52000) and prostate biopsy (55700), both for improved patient safety and also in rural settings because of improved patient convenience. Therefore I urge you not to delete these procedures from the group of procedures approved for ambulatory surgery centers.

Thank you for your attention to this matter and for your efforts on behalf of our patients.

William D. Mauch, M.D., F.A.C.S.

WDM/jbs

Submitter : **Dr. Randy Hassler** **Date: 01/24/2005**

Organization : **Salina Urology Associates Care Center, L.L.C.**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1478-P List of Proposed Deletions for Ambulatory Surgery Centers

Dear Sirs:

It has been brought to my attention that CMS is proposing significant deletions for procedures covered for ambulatory surgery centers. Our office has recently gone to significant expense in setting up an ambulatory surgery center to provide for our patients? a higher level of care plus more convenience and safety. We live in a rural area in Central Kansas where travel for many of our elderly patients is difficult and the ability to perform relatively simple procedures such as cystoscopy, in a setting where anesthesia is available allows us to perform these exams in a much safer environment, with much more accuracy and the option of therapeutic treatment in the same setting. It also saves the patient and Medicare the cost of utilizing a hospital for the same information.

I would encourage CMS to seriously reconsider their proposed deletions of procedures for ambulatory surgery centers because of its impact on quality of care, cost and convenience particularly in rural America.

I thank you in advance for your consideration and if I can be of any further help, please feel free to contact me at any time.

Randy D. Hassler, M.D.

RDH/jbs

Submitter : **Dr. Brian Smith** **Date: 01/25/2005**

Organization : **Salina Urology Associates Care Center, L.L.C.**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Attn: CMS-1478-P List of Proposed Deletions for Ambulatory Surgery Centers

Dear Sirs:

Recently it has come to my attention that several deletions have been proposed for ambulatory surgery centers including cystoscopy 52000, cystoscopy with dilatation 52281, and prostate biopsy 55700.

I practice medicine in a rural area, and believe that if these deletions went through that there would be significant problems with regard to patient care, as well as cost to Medicare. Many patients appropriately are evaluated cystoscopically in the clinic setting, as well as undergo biopsy without requiring an ambulatory surgery center or hospitalization. There are, however, a good number of patients that require more monitoring and more anesthetic than can be delivered in the clinic setting. All of these patients would require in-patient hospitalization, especially in this rural area. I believe this would prove very inconvenient for patients, as well as costly for Medicare if these deletions were to go through.

Thank you for your consideration.

Brian G. Smith, M.D.

BGS/jbs

Submitter : **Dr. John Lin** **Date: 01/25/2005**

Organization : **Western Urological Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1478-P-169-Attach-1.PDF

Submitter : **Dr. Brad Lerner** **Date: 01/25/2005**

Organization : **Urologic Surgery Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a clinical Urologist and Medical Director of our Ambulatory Surgery Center, I am opposed to the proposed deletions of 52000, 52281 and 55700 from the list of approved ASC procedures. The safety and quality of care given to our patients is far superior in an ASC setting than that which could be given in an office setting. Our ASC provides in-depth monitoring capabilities, a sterile environment as well as the ability to perform additonal intervention when an unplanned abnormality is detected (such as the finding of a bladder tumor while performing a cystoscopy - 52000 - with the ability to then perform a biopsy and fulguration at the same time). Being able to perform multiple procedures in the same operative session in an ASC setting if needed is better for the patient and is more cost effective. Placing this in the office setting would take this ability away and require procedures to be performed at different sessions (diagnostic and then therapeutic instead of diagnostic and therapeutic at the same setting). New regulations concerning the sterilizing of certain equipment would be difficult to carry out in an office setting as well (chemicals and ventilation hoods). Performing theses procedures in an ASC setting also enables one to be prepared for any adverse response or emergency as a trained RN is always on the premises as well as emergency equipment. This would not be the case in an office setting. The performance of a Cystoscopy with urethral dilation (52281) is a painful procedure which many times requires further procedures and special instrumentation as well as intravenous sedation or general anesthesia and would not be suited for an office setting. The performance of Prostate Biopsies (55700) involves the use of an Ultrasound machine and more advanced anesthesia techniques given the present biopsy recommendations. Patients are at risk for bleeding and infection and an ASC setting provides a safer environment than does the office. Our ASC is constantly undergoing inspections and reviews for safety and credentialling purposes and provides a safe, sterile, cost-effective and friendly environment for our patients at all times. Removing 52000, 52281 and 55700 from the list of approved ASC procedures will force these patients to go to the hospital for their care as an office setting will not be able to effectively provide our patients with the needed safety, sterility and flexibility as far as procedures, equipment and trained personnel. Please reconsider the proposal to delete 52000, 52281 and 55700 and allow these procedures to continue to be performed and reimbursed in the ASC setting.

Brad Lerner, MD
Urologic Surgery Associates

Submitter : **Mr. Scott Wolven** **Date: 01/25/2005**

Organization : **Ethicon**

Category : **Device Industry**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

We strongly support the addition of Current Procedural Code (CPT) 57288, Sling operation for Stress Incontinence (e.g. Fascia or synthetic) to Medicare?s approved 2005 ASC CPT code list, with assignment to payment Group number 9.

CMS-1478-P-171-Attach-1.DOC

Submitter : **Dr. Kenneth Ring** **Date: 01/25/2005**

Organization : **Dr. Kenneth Ring**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. William Becker** **Date: 01/25/2005**

Organization : **Dr. William Becker**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

CPT codes 52000,52281, &55700 should not be deleted from the Medicare ASC list of covered services for these reasons:

*ASC provide safe and efficient settings, less costly than hospitals. Deleting these codes will add to costs of care.
*ASC provide care for patients with cancer, fear/anxiety,scarring from radiatio/surgery, complex comorbidities. "Simple" diagnostic procedures lead to the discovery of other problems that can be safely treated in the ASC setting.

these codes will increase expense of care.
*ASC allow treatment for patients with cancer, prior radiation, scarring from surgery, fear/anxiety, etc, where unexpected conditions can often be treated at one visit to the ASC OR.
*

Submitter : Dr. S Schwartz **Date:** 01/25/2005

Organization : AP&S, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly urge CMS to replace CPT codes 52000, 52281 and 55700 on its list of covered services. The majority of cystoscopies, urethral dilitations and transrectal ultrasounds are performed in the office already. However, about 5-10% of the procedures have complicating factors. The majority are men. Some have had previous rectal surgery making the placement of a transrectal probe intolerable without intrvenous sedation or general anesthesia. In our location the hospital does not have the radiologic equipment necessary to perform transrectal ultrasound, so these patients would not be able to have the procedure without traveling over 70 miles to the next closest facility. Other patients have had previous surgery, limited mobility or previous radiation therapy making cystoscopy and/or urethral dilation particular painful and difficult and require/request sedation or anesthesia. Many of our patients have significant co-morbidities and require more intensive monnitoring, oxygen administration etc., or intravenous antibiotic administration for endocarditis prophylaxis, beyond our ability to perform in the office. This is most effectively, safely and efficiently administered on our ASC. I don't believe any cost savings will be afforded if these codes are eliminated. The only paitents that require use of the ASC or hospital are done there. All procedures are done in the office that can be. Therefore, if the ASC cannot be used, a hospital will be at a presumably higher cost. I think the option to use and ASC should be maintained and the decision on the best location for the procedure be left to the patient and his physician. Please replace CPT codes 55821,52000 and 55700 back on the ASC covered services list. Thank you.

Issues

Proposed Additions to the list of ASC covered procedures.

Replace 52000, 52281 and 55700 on list of covered services

Submitter : **Dr. Paul Sabini** **Date: 01/25/2005**

Organization : **Dr. Paul Sabini**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1478-P-175-Attach-1.DOC

Submitter : **Dr. Paul Sabini** **Date: 01/25/2005**

Organization : **Dr. Paul Sabini**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1478-P-176-Attach-1.DOC

Submitter : **Dr. Mark Hassel** **Date: 01/25/2005**

Organization : **DermaSurgery Specialists, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attached Microsoft Word File

CMS-1478-P-177-Attach-1.DOC

Submitter : **Dr. George Jones** **Date: 01/25/2005**

Organization : **Dr. George Jones**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I don't have an interest in an asc nor do I use one to a great extent. I do believe that deleting 5200,52281 and 55700 from the asc list is inappropriate. There are circumstances in which using a non office location for these procedures when anesthetic is required is appropriate. Forcing the procedures to a hospital may not be the most economical or appropriate choice. (Our hospitals do not have ultrasound devices for prostate biopsy.) Certainly, routine cystos without general, spinal anesthetic should not be performed in an asc, but there are times when it is the most appropriate location and should be reimbursed

Submitter : **Dr. dennis Gaskill** **Date: 01/25/2005**

Organization : **Yakima Urology Associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Dear CMS,
Six years ago our urology practice invested in an outpatient surgery center specifically for urology. We have enjoyed a three-fold increase in efficiency and have provided patients with a service that provides increased safety, comfort and cost savings. We now had the ability to perform uncomfortable procedures namely cystoscopy with instrumentation and prostate biopsy with conscious sedation. Prior to the surgery center we would perform cystoscopy and transrectal prostate biopsy in the office in a much less sterile environment without any sedation. Patients really appreciated our attempts to make their experience as painless as possible with cost effectiveness and safety.
With the passage of the new guidelines which eliminate cystoscopy and prostate biopsy our ability to serve our patients will be greatly compromised. We cannot safely perform conscious sedation in an office setting without proper monitoring and recovery. For many patients we will have to move their procedures to the hospital which for us is much less efficient and certainly not cost effective.
I urge you to reconsider dropping cystoscopy and prostate ultrasound with biopsy allowing us to provide the most cost effective, safe and comfortable service to our patients.
Sincerely,
Dennis Gaskill M.D.

Submitter : **Dr. Timothy Roddy** **Date: 01/25/2005**

Organization : **Sound Urological Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs-

I am writing to comment against the deletion of codes 52000 (cystoscopy), 55700 (prosate biopsy) and 52281 (cysto with urethral dilation) from the list of approved ASC procedures.

We have been performing these procedures in our ASC since February, 2000 and know the difference it has made in our patient care because we were doing it the old way in our office before. There is no comparison between the degree of patient care and safety that we can offer to our patients in the ASC versus the office setting.

I would be uncomfortable going back to the days of "minimalist" care especially when we are talking about the care of elderly patients with multiple health risk factors. We continue to make forward strides in the care of these patients and it's not fair to put them at risk under the guise of "saving money". We look for ways everyday to practice efficient, cost effective medicine and do so with more careful consideration of tests/studies that we order, length of stay for patients in the hospital, and judicious use of medicines. Medicare patients deserve access to reasonable and cost effective medical services. I will continue to practice the most cost effective medicine I can for the patients that walk in my door but I cannot compromise that care in any way for the sake of saving money. There are too many other ways this can de done. I ask you to reconsider your decision and keep codes 52000, 52281 and 55700 on the ASC procedure list. Thank you for your time.

Respectfully,

Timothy M. Roddy, MD

Submitter : **Dr. Terrence Gleasooon** **Date: 01/25/2005**

Organization : **Western Urological Associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

In regards to the proposal to delete CPT codes 52000, 52281, and 55700 from the Medicare ASC list of covered services, these services need to remain for the following reasons.
Many of the procedures which start out as code 52000 subsequently become more complicated procedures which would otherwise need to be done in a separate visit in a hospital outpatient setting. Having the procedure done in an ASC allows the patient tohave complete treatment in one operative session, in a safe, sterile environment.
Several times a week, a patient in our ASC will have surveilance cystoscopy for recurrent bladder cancer and will have abnormal lesions which are biopsied at that time, saving the patient the extra cost incurred in time and money needed with a repeat procedure.
This is also a savings to Medicare because only one procedure is done and done in a lower cost setting than a hospital outpatient department.
Cystoscopy with urethtral dilation, CPT code 52281, is often a painful procedure which is best done with the availabilty of sedation and anesthesia if required at the time of the procedure.
Further, the use of sedation should always have proper monitoring and availability of hopefully unnecessary emergency equipment with is not available in an office setting.
Many of the percieved savings the Medicare would expect to recoup form these deletions would be lost to having the procedures done in the hospital and from admissions to the hospital for increased complications form having the procedures done in an inappropriate office setting.
Finally, removing the procdures from the ASC list would deprive patients and doctors of the choice to have procedures done in setting that they hav chosen as the most appropriate setting for that individuals disease process and medical condition.

Thank you for your consideration of these very important issues.
Terrence P Gleason, MD

Submitter : **Dr. Frederick Cahn** **Date: 01/25/2005**

Organization : **BioMedical Strategies, LLC**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

Issues

Proposed Additions to the list of ASC covered procedures.

Codes 15342 and 15343

CMS-1478-P-182-Attach-1.RTF

CMS-1478-P-182-Attach-1.RTF

Submitter : **Dr. Frederick Cahn** **Date: 01/25/2005**

Organization : **BioMedical Strategies, LLC**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Additions to the list of ASC covered procedures.

CPT Codes 15342 and 15343

CMS-1478-P-183-Attach-1.RTF

CMS-1478-P-183-Attach-1.RTF

Submitter : **Dr. John Maldazys** **Date: 01/25/2005**

Organization : **Sound Urological Associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I am writing to express strong disagreement with the CMS proposal to eliminate codes 52000 (cystoscopy, 52281 (cystoscopy with urethral dilation, and 55700 (prostatic needle biopsy)from the list of Ambulatory Surgery Center procedures. Deletion of these codes will have a negative impact on the health and well being of patients.

In an ASC, these procedures are performed under standards of sterility and patient momitoring which are the equivalent of a hospital operating room. Although procedures 52000 and 52281 may be performed in an office setting, in the past they were generally done in a multipurpose room which, due to increased traffic and multiple uses, provides a much less clean environment and much greater probability for breaks in sterile technique. This would be expected to lead to an increase in procedure-related infections and complications, which would consume additional financial resources to rectify. Although procedure 55700 is a clean, rather than sterile procedure, it is often moderately uncomfortable for patients and causes vasovagal episodes and other vital sign alterations. In the ASC, these physiologic problemss are easily identified and appropriately managed through continuous vital sign and blood oxygen level monitoring, and rapidly availability of IV fluid and emergency resuscitation equipment. This level of patient support and backup is not available in the office.

In addition, the ASC can accomodate patients for these procedures who require special care because of comorbid conditions which are common in Medicare benificiaries. If the listed codes are removed from the ASC approved list, manypatients would therefore need to have the procedures performed at the outpatinet setting at a hospital , which would add costs instead of savings.

Furthermore, the proposal to delete these codes appears to be based in faulty methodology, as financial impact was calculated using outpatient and ASC payment information which is greater than 3 years old, and therefore, overestimates potential cost savings.

Last, using site of service thresholds as a principle factor in the decision to these codes from the approved list is arbitrary and does not appropriatley weigh the negative impact on patient care, or the negative impact on the fiscal health of physician practices. Delection of these codes will likely increase the difficulty of Mediciare beneficiaries in obtaining access to Urology specialty care.

Respectfully,

John D. Maldazys, MD

Submitter : **Mr. Samuel Shepard** **Date: 01/25/2005**

Organization : **American Association of Clinical Urologists**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

Issues

Proposed Deletions from the list of ASC covered procedures.

Proposed deletion of CPT codes 52000,52281,55700.

CMS-1478-P-185-Attach-1.PDF

CMS-1478-P-185-Attach-1.PDF

Submitter : **Mrs. Cindy Ladner** **Date: 01/25/2005**

Organization : **Shawnee Mission Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

RE: Proposed Changes to ASC List

On behalf of our patients, we are concerned with the proposed changes to the ASC list. We have done a thorough review of the procedure codes on the list. The following proposed codes to be deleted have been performed in our Surgery Center: 11404 ? 20670, 25505, 26605, 31237, 31238, 52000, 55700, 65800, and 65805. These codes, with rationale number 2, have been performed safely with positive outcomes in our center. If these procedures are removed from the ASC list, many will be transferred to hospital operating room settings, increasing the cost significantly for our patients and CMS. Codes with rationale number 4 are performed on senior citizens who frequently have health conditions that require a higher level of care than in physician offices. These patients are entitled to the standard of care that is provided in an ASC.

We represent 25 surgeons who work at Shawnee Mission Surgery Center, LLC, a multi-specialty, hospital-based ASC in Kansas City. We are accredited by Joint Commission Accreditation of Healthcare Organizations. All of our patients are pre-screened by RNs to ensure the highest quality of patient care and safety. National patient safety goals have been a major focus for our center.

We support the proposed addition of ASC codes and hope that you will continue to evaluate new codes each year. For the sake of the patients at our Surgery Center, we strongly urge your reconsideration of these deletion codes.

Sincerely,

Cindy Ladner, BSN, RN Vikki Zagortz, CPC
Administrator BusinessManager
913-676-7710 913-676-7771

Submitter : **Mr. Jeff Pearcy** **Date: 01/25/2005**

Organization : **AAAASF**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachments"

CMS-1478-P-187-Attach-2.DOC

CMS-1478-P-187-Attach-1.DOC

Submitter : **Dr. Gary Jolly** **Date: 01/25/2005**

Organization : **American College of Foot & Ankle Surgeons**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issues

Proposed Additions to the list of ASC covered procedures.

Support 15001 and 15839
Need to add 0020T (2825X), 28108, 28230, 28232

Proposed Deletions from the list of ASC covered procedures.

Oppose 11404, 11424, 11604, 11624, 12021, 13120, 13121, 13131, 13132, 14040, 14041, 20670.

CMS-1478-P-188-Attach-1.DOC

CMS-1478-P-188-Attach-1.DOC

CMS-1478-P-188-Attach-1.DOC

Submitter : **Dr. michael alabaster** **Date: 01/25/2005**

Organization : **aua**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

Proposed Deletions from the list of ASC covered procedures.

code CMS-1478-P

As a urologist I find it perplexing that prostate biospy code is on this list. The standard of care is now requiring up to 12 to 14 cores ,which are seperate biospies at one setting. This causes great discomfort to the patients and really benefits by having IV sedation monitered anesthesia.

Please consider removing all 5200 codes ,but particulary 55700.

thanks Mike alabaster MD.code

Submitter : **Ms. Anne Marie Bicha** **Date: 01/25/2005**

Organization : **American Gastroenterological Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-190-Attach-1.DOC

Submitter : **Dr. Joel Sears** **Date: 01/25/2005**

Organization : **Advanced Dermatology & Skin Surgery**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

I oppose the deletion of CPT codes 13100-13152, 14000-14061 and 15740 from the list of ASC covered procedures. I am a skin cancer specialist and utilize these complex closures, skin flaps and grafts for facial reconstruction after skin cancer surgery.

If these codes are deleted from the list, these procedures will cease to be performed in the ASC setting and would be relegated to either the un-regulated office setting or the hospital. Neither of these alternatives are in the patients' best interest.

It is inappropriate to perform this level of surgery in an office setting which may not be adequately equipped or staffed. Currently there is no regulatory process to insure patient safety to do this level of surgery in a private office setting. Certification of an ASC facility provides a level of standards and oversight which will insure adequate equipment and personnel for appropriate patient care.

The hospital setting is, on the other hand, overkill. The increased cost does not justify any other unnecessary services the hospital might offer over the ASC. Furthermore, the inconvenience to both the patient and physician in the hospital would not be conducive to this level of outpatient surgical procedure. In addition, the hospital would potentially expose the patient to serious hospital-acquired infectious diseases such as MRSA.

I strongly urge you to remove the above listed CPT codes from the list of proposed deletions. Thank you for you consideration.

Joel K. Sears, MD
Spokane, WA

Submitter : **Mr. Tom Barthel** **Date: 01/25/2005**

Organization : **Clarus Medical, LLC**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1478-P-192-Attach-1.DOC

Submitter : **Date: 01/25/2005**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS should not delete codes 52000, 52281, and 55700 simply because Medicare patients are treated in the ASC setting simply because patients are safer in the ASC setting. Medicare patients tend to have more involved medical histories and often require the closer monitoring given in the ASC setting. Especially, prostate biopsies should definitely require a safer and more closely monitored environment, as complications such as bleeding can occur.

Of course, the ASC setting is much more sterile an evironment than an office setting. This would reduce the risk of infection with such procedures as cystoscopy.

Also, if such a change takes place, many urologists will now perform these procedures in the hospital setting to maintain the same standard of patient safety. Medicare costs will skyrocket as a result.

Also, and very importantly, many cystoscopies and prostate biopsies are done under iv sedation, which should not be done in an office setting, and should be done in the ASC simply because sedation patients must have continuous monitoring in an ASC setting, with nursing, vital sign monitoring, and anesthesia capabilities.

In summary, cystoscopy and prostate biopsies should be performed in the ASC setting for many Medicare patients because it is more efficient, significantly safer, and much more cost effective.

Issues

Proposed Additions to the list of ASC covered procedures.

I agree with adding the sling operation CPT code 57288 to the list of outpatient procedures because it can be performed easily, safely, and cost effectively in an outpatient setting.

Proposed Deletions from the list of ASC covered procedures.

Cystoscopy CPT code 52000
Cystoscopy with Urethral Dilation CPT code 52281
Prostate biopsy CPT code 55700

Submitter : **Dr. John Pettit** **Date: 01/25/2005**

Organization : **Dr. John Pettit**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Dear Sirs:

I am writing to comment against the deletion of codes 52000 (cystoscopy),55700(prostate needle biopsy)and 52281(cystoscopy with urethral dilation). All of these proceedures are often painful and should not be done in an offfice setting. They all require very expensive specialised equipment that would be hard to suply in an office setting. The result would probably require doing these proceedures in hospital at an additional cost.

In conclusion deletion of these codes would impact patient care and would shift these costs to the hospital.I urge you to not remove these codes from the ASC.

respectively John Pettit

Submitter : **Date: 01/25/2005**

Organization : **Physicians Day Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-195-Attach-1.DOC

Submitter : **Dr. Lloyd Smith** **Date: 01/25/2005**

Organization : **American Podiatric Medical Association**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-196-Attach-2.DOC

CMS-1478-P-196-Attach-1.DOC

Submitter : **Mr. Lawrence Lawrence Anderson** **Date: 01/25/2005**

Organization : **American Association of Ambulatory Surgical Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachments

CMS-1478-P-197-Attach-3.DOC

CMS-1478-P-197-Attach-2.PDF

CMS-1478-P-197-Attach-1.DOC

Submitter : **Mr. Lawrence Anderson** **Date: 01/25/2005**

Organization : **American Association of Ambulatory Surgical Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

We were disappointed and surprised to read the CMS ?Update of Ambulatory Surgery Center List of Covered Procedures? (CMS 1478-P) published on November 19, 2004. This seems to be a complete and sudden reversal of recent governmental attempts to improve the safety and standards of outpatient surgery. CMS 1478-P, if adopted will have a tremendous negative impact on both our practice and the care, which we provide our patients.

Dermatology Associates of Tyler has been providing quality medical and surgical dermatologic care for patients in East Texas since 1964. With eight board-certified dermatologists, three certified Physicians Assistants, and one Nurse Practitioner. we are one of the largest, oldest, and most comprehensive dermatology practices in the country. Our physicians include two fellowship-trained Mohs micrographic surgeons and two board-certified dermatopathologists. We take our profession very seriously, and have tried to provide the safest, most technically advanced, and most cost effective care to the citizens of East Texas

We have performed thousands of surgeries in our office setting with very few adverse events. Despite this established safety record, we found ourselves in a position in which numerous governmental agencies, state legislatures and other specialty societies such as Plastic Surgeons have been criticizing the safety of office-based surgery. State medical boards, state legislatures, some specialty societies and federal governmental agencies have been demanding higher standards in outpatient surgical care. There have been numerous proposals in which reconstructive surgeries for skin cancer would be restricted to ambulatory surgery centers or hospitals. In fact, several years ago the American Society for Plastic Surgery mandated to that its members only operate in accredited facilities. Their website states: The mission of ASPS is to advance quality care to plastic surgery patients by encouraging high standards of training, ethics, physician practice and research in plastic surgery. The society advocates for patient safety, such as requiring its members to operate in accredited surgical facilities that have passed rigorous external review of equipment and staffing.

These governmental directives, coupled with an increasing complex surgical caseload (e.g. greater numbers of immunocompromised surgical patients with HIV or solid organ transplant histories; fragile cardiovascular status; more elderly patients), led us to seriously reconsider our historically proven, but potentially outdated, mode for providing surgical care primarily in an office setting.

With the average life expectancy rising in recent years, we are seeing a greater number of surgery patients aged 90-100 years old. These patients are often referred to us for advanced reconstructive surgery under primarily local anesthesia because the hospital-based anesthesiologists and plastic surgeons refuse to perform the needed surgery in the inpatient setting, citing concerns about potential general anesthesia complications. Clearly, these fragile patients have nowhere else to go and benefit from having their surgeries done by a qualified Mohs surgeon in an ASC setting.

In 2002, we embarked on an ambitious and rather intimidating project to meet governmental calls for higher standards in outpatient surgery. We constructed an on-site, state-of-the-art ambulatory surgery center in which we could perform our numerous complex reconstructions (e.g. complex linear closure, adjacent tissue transfers, grafts) for patients afflicted by serious skin cancers. We cannot adequately care for patients at any other location since no hospital or ASC in our area currently possess the necessary staffing, knowledge, or equipment to perform Mohs horizontal sectioning of skin cancer specimens which offers the highest cure rate. In addition, the local hospitals simply do not have adequate operating room space to (See Attachment - Larry CMS)...

CMS-1478-P-198-Attach-3.DOC

CMS-1478-P-198-Attach-2.PDF

CMS-1478-P-198-Attach-1.DOC

Submitter : **Mr. Robert Burns** **Date: 01/25/2005**

Organization : **American Dental Association**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issues

Proposed Additions to the list of ASC covered procedures.

Both the American Dental Association (ADA) and American Association of Oral and Maxillofacial Surgeons (AAOMS) commend CMS for its willingness to add several maxillofacial procedures to the list of those Medicare will cover in an ASC setting.

Proposed Deletions from the list of ASC covered procedures.

Both the American Dental Association (ADA) and American Association of Oral and Maxillofacial Surgeons (AAOMS) believe it vital that that 21 of the now-covered maxillofacial procedures (see attached) be retained on the list.

(1) The rule does not account for the high frequency with which these procedures (see attached) are performed among younger, non-disabled patients. These patients will be disproportionately affected by this rule change because private insurers will likely follow Medicare's lead in eliminating coverage for these services.

(2) The rule was developed without the input of dental professionals and, thus, may not reflect objective, clinically sound principles.

(3) The rule undermines the authority of practitioners to decide when a patient's medical condition, age, or anesthetic requirement warrants treatment in an ASC.

CMS-1478-P-199-Attach-2.DOC

CMS-1478-P-199-Attach-1.DOC

CMS-1478-P-199-Attach-2.DOC

CMS-1478-P-199-Attach-1.DOC

CMS-1478-P-199-Attach-2.DOC

CMS-1478-P-199-Attach-1.DOC

Submitter : **Robert Zwolak** **Date: 01/25/2005**

Organization : **Society for Vascular Surgery**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

The following comment is submitted by the Society for Vascular Surgery

The Society for Vascular Surgery (SVS) is pleased to submit the following comments in response to CMS 1478-P for ambulatory surgical centers (ASCs). We believe that the current regulations guiding ASC-approved services do not meet the needs of patients, providers, or CMS, and we appreciate the Agency?s willingness to attack this issue. SVS urges CMS to develop a system in which ASCs can be fairly reimbursed by Medicare for services that are safely performed in that setting.

Regarding Criteria for ASC Covered Services

Currently, the criteria CMS uses to determine whether a procedure should be added to the ASC list require that the procedure not exceed 90 minutes of operating time. It is SVS opinion that the 90-minute time limit is somewhat arbitrary. Given the excellent quality of current anesthetic techniques, plus the fact that operations and procedures lasting more than 90 minutes are not necessarily linked to cardiovascular instability or major morbidity, our society believes this time limit could be expanded or perhaps deleted. A surgical time limit is not a good proxy for identifying procedure safety. The Medicare Payment Advisory Commission (MedPAC) recently recommended that CMS use only two criteria to determine which procedures should be allowed Medicare reimbursement when performed in an ASC; first, the procedure can safely be performed in an ASC, and second, the procedure can be performed without an overnight stay. SVS believes this is a reasonable approach, and we urge adoption of the recommended criteria.

SVS is concerned about the wording of exclusionary phrase for procedures that ?directly involve major blood vessels?. The brachial and femoral arteries are major blood vessels, yet appropriately, the ASC-approved list contains open operations on major arteries of the upper extremity (CPT 36819, 36820, 36821) and the lower extremity (CPT 35875, 35876). Perhaps more accurate wording would be procedures that ?directly involve open surgery on major blood vessels of the chest, abdomen and pelvis?.

SVS notes that percutaneous transcatheter stent placements codes 37205 and 37206 are listed as proposed additions in CMS-1478-P. We agree that these services may safely be performed in the ASC setting, but we note that analogous services such as the family of percutaneous balloon angioplasty codes have not been appended. Likewise, arterial and venous catheter placement codes are not on the current ASC list, and catheterization is always necessary prior to performing the approved stent procedures. Our Proposed Addition list includes these catheterization and angioplasty codes.

Proposed Additions

SVS believes that the following services may be performed safely in properly selected individuals. We emphasize the fact that the ASC is not an appropriate treatment site for all vascular disease patients. More than other patient cohorts, patients with advanced arterial and venous disease require extremely careful pre-operative evaluation to determine whether percutaneous intervention and/or surgery are appropriate treatment options, and also to determine whether an ASC will be a safe site-of-service.

Issues

Proposed Additions to the list of ASC covered procedures.

C
CPT 2005 Long Descriptor
28800 Amputation, foot; midtarsal (eg, Chopart type procedure)
28805 Amputation, foot; transmetatarsal
35470 Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel
35471 Transluminal balloon angioplasty, percutaneous; renal or visceral artery
35472 Transluminal balloon angioplasty, percutaneous; aortic
35473 Transluminal balloon angioplasty, percutaneous; iliac
35474 Transluminal balloon angioplasty, percutaneous; femoral-popliteal
35475* Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
35476* Transluminal balloon angioplasty, percutaneous; venous
36005 Injection procedure for extremity venography (including introduction of needle or catheter
36010 Introduction of catheter, superior or inferior vena cava
36011 Selective catheter placement, venous system; first order branch (eg renal vein, jugular vein)
36012 Selective catheter placement, venous system; second order, or more selective branch (eg left adrenal vein, petrosal sinus)
36120 Introduction of needle or intracatheter, retrograde brachial artery
36140 Introduction of needle or intracatheter; extremity artery
36145 Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)
36200 Introduction of catheter, aorta
36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family
36216 Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family
36217 Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

36218 Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)
36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36246 Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36247 Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery
36248 Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal
36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk
36469 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face
36470 Injection of sclerosing solution; single vein
36471 Injection of sclerosing solution; multiple veins, same leg
36475 Endovenous ablation therapy of incompetent vein, extremity,
36476 Endovenous ablation therapy of incompetent vein, extremity,
36478 Endovenous ablation therapy of incompetent vein, extremity,
36479 Endovenous ablation therapy of incompetent vein, extremity
36818 Arteriovenous anastomosis, open; by upper arm cephalic
37205* Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; initial vessel
37206* Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; each additional vessel
37250 Intravascular ultrasound (non-coronary vessel)
37251 Intravascular ultrasound (non-coronary vessel)
37500* Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37620 Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)
37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
37766 Stab phlebectomy of varicose veins, one extremity; more than 20 stabs

CMS-1478-P-200-Attach-2.DOC

CMS-1478-P-200-Attach-1.DOC

CMS-1478-P-200-Attach-2.DOC

CMS-1478-P-200-Attach-1.DOC

Submitter : **Dr. Craig Birkby** **Date: 01/25/2005**

Organization : **Dr. Craig Birkby**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Attached is a photo of the type of flap repair presently done safely and cost effectively in an ASC setting. If the proposed deletions go through, this type of surgery would have to be done in an unregulated office setting or the hospital

Issues

Proposed Deletions from the list of ASC covered procedures.

1/25/05
RE:CMS 1478-P
Reference to CPT codes:
11404,11424,11444,11445,11604,11624,11644,13100,13101,13120,13121,13131,13132,13150,13151,13152,1400,14020,14021,14040,14041,14060,14061,15732,15740

Dear CMS:

I am writing in opposition to deletion of the above codes as stated in CMS-1478-P. For patient safety and care these are clearly procedures for which use of an ASC is indicated.

The extent of some of these procedures involving movement of large areas of skin, subcutaneous tissue and muscle, the exposure of underlying nerves, vessels and glands, and the risk of morbidity and death only a few millimeters away from the scalpel for some of these procedures is clearly an indication for some of these procedures to be performed in a controlled and regulated ASC.

In addition to sometimes extensive and dangerous nature of these procedures, proper monitoring of the patients, many with multiple medical conditions that put them at an increased risk, is also needed. To have this relegated to a hospital, exposes the patient to at times unnecessary expense, discomfort, extra test, and a greater risk for hospital acquired infections. These procedures, however, could be done safely in the controlled setting of an ASC.

The proposed deletions of flap and complex repairs would not only expose the patients to increased risk, it would also decrease accessibility. Many reconstructive surgeons will forgo accepting patients if the surgeon is forced to do the procedure in the hospital, when the procedures can be accomplished safer, cheaper and with more convenience to both the patient and surgeon if it is performed in an ASC.

I strongly urge you to forgo the proposed deletions for flap and complex skin repairs. I feel delegating these procedures to only hospitals and unregulated offices is not in the best interest of proper medical care and is counter to the Medicare program.

Sincerely,

Craig Birkby MD
Director, Seattle Skin Cancer Center

Submitter : **Dr. Michael Maves** **Date: 01/25/2005**

Organization : **American Medical Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment...

CMS-1478-P-202-Attach-1.PDF

Submitter : **Mr. Cory Doman** **Date: 01/25/2005**

Organization : **Intermountain Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Following are codes of procedures currently being provided to patients of all ages by Intermountain Surgery Center in Boise, Idaho: 24576, 24670, 25505, 26605, 27780, 27786. These codes are included on the ASC list for proposed deletions. We are an orthopaedic specialty ASC and have provided outpatient treatment for hundreds of extremity fractures. The proposed codes for deletion are for closed treatment of the radius, ulna, humerus, fibula or metacarpal. The ASC is the ideal healthcare setting for closed treatment of these fractures that requires manipulation for reduction. When these types of fractures require manipulation, it is often difficult to predict the amount of manipulation necessary until the procedure is attempted. Aggressive manipulation can be painful and require pain control measures and muscle relaxation. This dictates the need for an anesthesia provider to perform proper sedation in order to control the pain and relax the muscles around the fracture. To maintain what is in the patient's best interest, this needs to take place in an operating room and requires proper post-operative recovery. Typical OR time is from 30-45 minutes, typical anesthesia time is from 10-30 minutes and typical recovery times are from 30-60 minutes. These procedures are not life-threatening in nature, require no invasion of body cavities, do not involve major blood vessels, nor result in any blood loss. It has been our experience in comparing the costs associated with providing services in an outpatient physician owned ASC to an outpatient department of a hospital, that the ASC can render the service for less expense. Our experience is also backed by the Office of the Inspector General who in 2003 conducted a study on outpatient payment procedures and reported that of the outpatient codes studied, for 66% of them Medicare paid an ASC less than they do for the same service performed in a hospital. It was further concluded that Medicare could have saved an estimated $1.1 billion if these procedures would have been performed in an ASC. 32% of the savings are from one code: cataract surgery. I see no reason to require that these procedures be done solely in a hospital setting, and see multiple reasons why these procedures could require more than can be provided for in an office-based setting. The ASC setting is clearly the best place for these procedures to take place.

Submitter : **Mr. Steven Pimental** **Date: 01/25/2005**

Organization : **Same Day SurgiClinic**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-204-Attach-2.DOC

CMS-1478-P-204-Attach-1.WPD

Submitter : **Ms. Laura Saul Edwards** **Date: 01/25/2005**

Organization : **American Academy of Dermatology Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment, a comments letter co-signed by the AADA, ASDS and ACMMSCO.

CMS-1478-P-205-Attach-2.DOC

CMS-1478-P-205-Attach-1.DOC

Submitter : **Mrs. Rachel Kramer** **Date: 01/25/2005**

Organization : **ACR**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1478-P-206-Attach-1.PDF

Submitter : **Ms. Laura Saul Edwards** **Date: 01/25/2005**

Organization : **American Academy of Dermatology Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attached letter--correct version--joint letter submitted by AADA, ASDS and ACMMSCO.

Submitter : **Date: 01/25/2005**

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1478-P-208-Attach-1.DOC

Submitter : **Dr. Michael Repka** **Date: 01/25/2005**

Organization : **American Academy of Ophthalmology**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attached letter and PDF files

CMS-1478-P-209-Attach-3.PDF

CMS-1478-P-209-Attach-2.PDF

CMS-1478-P-209-Attach-1.DOC

Submitter : **Ms. Nancy Petty** **Date: 01/25/2005**

Organization : **Grand Valley Surgical Center LLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issues

Proposed Additions to the list of ASC covered procedures.

Lap Cholecystectomy 47562
Retain all lesion excision codes, closure, and tissue tranfer codes proposed for deletion based on OIG rationale. CPT 11404 to 14061

CMS-1478-P-210-Attach-1.DOC

CMS-1478-P-210-Attach-1.DOC

Submitter : **Mr. Stryker Warren** **Date: 01/25/2005**

Organization : **CIMplify**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

January 25, 2005

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS ? 1478-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare ASC List Changes

To Whom It May Concern:

I write on behalf of 9 urology practices with whom CIMplify works. My comments are directed toward the CMS proposal to update the Medicare ASC list of covered procedures effective July 1, 2005.

? CPT 57288: I recommend that CMS treat the sling operation for stress incontinence as a ?group 9? payment; I also recommend the sling material be reimbursed separately.
? CPT 53850: I recommend that TUMT (transurethral microwave thermotherapy) be deleted from the ASC list. We concur that this should be done in the physician?s office.
? CPT 52000 and CPT 52281: While cystoscopies are frequently done in the urologist?s office, there are numerous presentations where the patient?s medical condition causes the treating physician to choose the ASC over the office. All of the urologists whom CIMplify represents feel strongly about CPT codes 52000 and 52281 remaining on the ASC list due to patient health and medical condition selection criteria. Furthermore, cystoscopies can be complex and painful?requiring sterile environments and the ability to render sedation.
? CPT 55700: While often done in the urologist?s office, prostate biopsies frequently require IV sedation due to the use of a transrectal ultrasound and the discomfort of the biopsy process itself?with up to 20 separate biopsies performed.
? CMS should clarify which CPT Code the GreenLight laser (for treatment of BPH) deserves?either 52647 or 52648 and then, reimburse for it accordingly. While they are currently grouped as a Group 9 (national average Medicare payment of $1,339), there is no accounting nor recognition of the fiber?s cost of $700 - $1,000. This makes the procedure unprofitable in an ASC-setting and dictates that the procedure be performed in the HOPD at $3,750. Urologists would agree that the appropriate site-of-service is an ambulatory surgery center. By reimbursing for the laser fiber (similar to CMS reimbursing for an IOL for cataract extractions), CMS would encourage and shift the GreenLight laser to the appropriate setting. In doing so, CMS would not only add convenience to the patients and physicians but generate cost savings?a win-win-win.

We strongly urge that CPT codes 52000, 52281 and 55700 remain on the CMS approved list for the ASC as the site of care. We also strongly urge appropriate reimbursement for the GreenLight Laser.

Sincerely,

Stryker Warren, Jr.

Stryker Warren, Jr.
President and Chief Executive Officer

cc: rhudson@auanet.org

CMS-1478-P-211-Attach-1.DOC

Submitter : **Ms. Sarah Wells** **Date: 01/25/2005**

Organization : **Boston Scientific Corporation**

Category : **Device Industry**

Issue Areas/Comments

Issues

Proposed Additions to the list of ASC covered procedures.

See Attached Letter

Proposed Deletions from the list of ASC covered procedures.

See Attached Letter

CMS-1478-P-212-Attach-1.PDF

CMS-1478-P-212-Attach-1.PDF

Submitter : **Dr. Casey O'Keefe** **Date: 01/25/2005**

Organization : **Cascade Urology Consultants**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Re: CMS-1478-P January 25,2005
Dear Sirs:
I am writing to comment against the deletion of codes 52000, 55700 and 52281 from the list of approved ASC procedures. The deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to patient health and safety. Let me explain:
52000-Cystoscopy is an often complex, painful procedure that, while often performed in a physician's office, frequently requires the more advanced capabilities of an ASC. It is beyond the expertise of an office setting to provide the often required sedation and post sedation monitoring for cystoscopy. Not only is it forbidden to administer such intravenous sedation in an office by many Medical Liability Policies, it is inherently unsafe.
It is not uncommon to do diagnostic cystoscopy only to find significant pathology that requires therapeutic intervention such as biopsy, resection, dilation, or other invasive treatment. In many cases that intervention can be addressed at the time of the cystoscopy.

The deletion of 52000 from the ASC list will be counter productive by effectively requiring duplication of a similar but more complex service in an ASC after the diagnostic service is done in the office. In an era when efficiency and cost effectiveness is the goal, this deletion of 52000 is counterproductive and represents a threat to patient health and safety.

52281- Dilation of a stricture that requires cystoscopic guidance is VERY painful and often VERY complex procedure requiring specialized equipment, dilators, personnel, as well as sedation and often full anesthesia. It does not necessarily require the hospital setting but does require the ASC setting in a large number of cases. It would be highly inappropriate to remove this code from the ASC approved list. It is simply not a procedure that can be done in an office setting routinely. Removing this option for management of urethral strictures would be a great disservice to patients and Urologist alike.

55700-Prostatic Biopsy, usually done in association with Transrectal ultrasound, now routinely includes 12-20 separate biopsies. It is uncomfortable and often includes intravenous sedation. It is unreasonable in today?s medical legal climate to expect Urologists to administer intravenous sedation without appropriate safeguards available only in an ASC or hospital setting. Again, withdrawing this option is a disservice to Patients and Physician alike.

In conclusion, the decision to delete codes 5200, 52281, and 55700 is not supported by any Urologic organization and opposed by nearly every colleague. Removing these codes is counterproductive and removes options for efficient and cost effective humane management of many medical conditions. I urge you to reconsider and reinstitute 52000, 52281 and 55700 as ASC approved procedures.

Respectively,

S. Casey O?Keefe, MD

Submitter : **Dr. William Griggs** **Date: 01/25/2005**

Organization : **Cascade Urology**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

Re: CMS-1478-P January 25,2005
Dear Sirs:
I am writing to comment against the deletion of codes 52000, 55700 and 52281 from the list of approved ASC procedures. The deletion of these three codes from the current ASC list of approved procedures will detract from patient care and will present a threat to patient health and safety. Let me explain:
52000-Cystoscopy is an often complex, painful procedure that, while often performed in a physician's office, frequently requires the more advanced capabilities of an ASC. It is beyond the expertise of an office setting to provide the often required sedation and post sedation monitoring for cystoscopy. Not only is it forbidden to administer such intravenous sedation in an office by many Medical Liability Policies, it is inherently unsafe.
It is not uncommon to do diagnostic cystoscopy only to find significant pathology that requires therapeutic intervention such as biopsy, resection, dilation, or other invasive treatment. In many cases that intervention can be addressed at the time of the cystoscopy.

The deletion of 52000 from the ASC list will be counter productive by effectively requiring duplication of a similar but more complex service in an ASC after the diagnostic service is done in the office. In an era when efficiency and cost effectiveness is the goal, this deletion of 52000 is counterproductive and represents a threat to patient health and safety.

52281- Dilation of a stricture that requires cystoscopic guidance is VERY painful and often VERY complex procedure requiring specialized equipment, dilators, personnel, as well as sedation and often full anesthesia. It does not necessarily require the hospital setting but does require the ASC setting in a large number of cases. It would be highly inappropriate to remove this code from the ASC approved list. It is simply not a procedure that can be done in an office setting routinely. Removing this option for management of urethral strictures would be a great disservice to patients and Urologist alike.

55700-Prostatic Biopsy, usually done in association with Transrectal ultrasound, now routinely includes 12-20 separate biopsies. It is uncomfortable and often includes intravenous sedation. It is unreasonable in today?s medical legal climate

It is not uncommon to do diagnostic cystoscopy only to find significant pathology that requires therapeutic intervention such as biopsy, resection, dilation, or other invasive treatment. In many cases that intervention can be addressed at the time of the cystoscopy.

The deletion of 52000 from the ASC list will be counter productive by effectively requiring duplication of a similar but more complex service in an ASC after the diagnostic service is done in the office. In an era when efficiency and cost effectiveness is the goal, this deletion of 52000 is counterproductive and represents a threat to patient health and safety.

52281- Dilation of a stricture that requires cystoscopic guidance is VERY painful and often VERY complex procedure requiring specialized equipment, dilators, personnel, as well as sedation and often full anesthesia. It does not necessarily require the hospital setting but does require the ASC setting in a large number of cases. It would be highly inappropriate to remove this code from the ASC approved list. It is simply not a procedure that can be done in an office setting routinely. Removing this option for management of urethral strictures would be a great disservice to patients and Urologist alike.

55700-Prostatic Biopsy, usually done in association with Transrectal ultrasound, now routinely includes 12-20 separate biopsies. It is uncomfortable and often includes intravenous sedation. It is unreasonable in today?s medical legal climate to expect Urologists to administer intravenous sedation without appropriate safeguards available only in an ASC or hospital setting.
Respectfully,
William Griggs, MD

Submitter : **Date: 01/26/2005**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

January 18, 2005

Mark B. McCellan MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services,
Attention: CMS-1478-P,
P.O. Box 8013
Baltimore, MD 21244-8013.

RE: Medicare Program: update of Ambulatory Surgery Center List of Covered Procedures; Proposed Rule; 69 Federal register 69178 (November 26, 2004); File Code CMS-1478-P

Dear Dr. McClellan:

The proposed changes would limit the number and type of surgeries that can be performed in an ambulatory surgery center (ASC). Specifically, I am referring to the American Medical Associations Current Procedural Terminology (CPT) codes in the 116_ _, 131_ _, 140_ _, 157 _ _ series. These codes deal with removal of skin cancers and subsequent reconstructive surgery.

I have been caring for Medicare recipients for over 15 years. In 1997, I built an ambulatory surgery center annexed to my office. This combination of the Mohs surgical unit/ambulatory surgical center (ASC) has markedly increased the quality and efficiency of the care I can provide my patients. Once the cancer has been removed in the Mohs surgical unit, the patient can immediately be admitted to the ASC for complex reconstructive surgery. Prior to 1997, patients often were referred to plastic surgeons or admitted to hospitals for extensive reconstructive surgery. If the proposed codes are deleted, I fear many more patients will be referred unnecessarily to the hospitals for reconstructive surgery.

I assume that these proposed ASC deletions are for cost-cutting purposes. But if these changes are more critically evaluated, I believe you will find them to be ?penny-wise and pound-foolish?. The intentions of the ASC is to provide the same standard of care the hospital operating room, but at a fixed and fraction of the costs. The ASC fees for the above-mentioned CPT codes are fixed rate. The same procedures done in a hospital setting would cost Medicare many times more. For example, operating room costs run $1500-2000/hour. Additional anesthesia cost, preoperative assessment, labwork and recovery room fees are substantial as well.

Finally, nosocomial (hospital acquired) infections can be a serious threat to patients? health and wound healing, and are substantially more resistant in the hospital setting.

In summary, deletion of ASC codes relating to skin cancer and reconstructive surgery would require more hospital admissions for the same procedures and would: 1) markedly increase the cost to Medicare, 2) substantially reduce the efficiency and quality of patient care, and 3) potentially increase the risk of more serious, hospital based nosocomial infections.

I respectfully request your most urgent attention to this matter. Thank you for your assistance in this healthcare issue.

Submitter : **Ms. Catherine Nichol** **Date: 01/26/2005**

Organization : **Titan Health Corporation**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Date: 01/26/2005**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly object to the deletion of CPT codes 52000 and 55700 from the list of approved ASC procedures.

There are many patients for whom in office cystoscopy or prostate biopsy is not possible. Reasons include concommitant medical conditions and patient pain and inability to tolerate the procedure in the office. If a patient is too uncomfortable, a careful cystoscopy and prostate biopsy is not possible. The patient therefore does not receive the most accurate and thorough examination and evaluation.

These patients (a significant number) therefore require these procedures under monitored IV sedation or general anesthesia. Urologists' offices are not equipped for such measures. Urologists are not qualified to administer this treatment or comfort measures.
The patient is therefore brought to a hospital to have these procedures done in the operating room.

But the operating room at a hospital is a very inefficient, time-consuming, and costly place to have these procedures done. It is costly to Medicare and other insurance plans.

For these patients, an ambulatory surgical center offers an excellent alternative. Safe, expedient, and cost-efficient care is available there. The patients are happier with their experience in these centers than in a hospital setting. The cost to the insurance companies is much less.

There are a significant number of patients who can not have cystoscopy or prostate biopsies performed in the office and must have them done in a hospital or ambulatory surgical center. The surgical center is the better option the whole way around - for the patient, doctor, and insurance company.

Please do not delete these codes from the list of approved ASC procedures.

Thank you.

Submitter : **Dr. Lisa Hawes** **Date: 01/26/2005**

Organization : **Central Maryland Urology Associates**

Category : **Physician**

Issue Areas/Comments

Issues

Proposed Deletions from the list of ASC covered procedures.

January 21, 2005

To Whom It May Concern:

I would like to express my concerns about CMS? plan to remove codes 52000 (cystoscopy), 52281 (cystoscopy and dilation) and 55700 (Prostate biopsy) from ASC level care.

When a physician determines a patient needs one of these procedures, the physician does not know what problems may be encountered and what complications may occur. Commonly found problems include dense urethral strictures, bladder tumors, bladder stones, urethral stones and urethral diverticuli. In an ASC setting some of these findings can be treated simultaneously. For example strictures may be dilated, bladder masses can be biopsied and fulgurated and small stones may be removed. However all of these interventions require the right equipment available and sterile as well as having trained staff around to assist as necessary. Neither of these requirements is available in an office setting. Therefore another procedure would be required to solve diagnosed problems, increasing risks to the patient, inconveniencing the patient and increasing the cost to Medicare.

Second, all these surgeries have serious complications including hemorrhage, infection, sepsis, bowel and bladder perforation to name a few. Many patients pass out or feel light-headed after these procedures. Some need to be closely monitored and even transferred to the hospital for further evaluation and emergency care. In the ASC we can carefully monitor patients with blood pressure and pulse oximetry as well as trained nurses. Cardiac life support is readily available. Much of this care is not available in an office setting.

Third, I am concerned about timely access to care. An ASC can handle many types of patients from the sick to the healthy safely. We can administer antibiotics, IV fluids, sedation and pain medication as needed. None of this is available in an office setting. Therefore I will be forced to perform procedures on the elderly, sick and those requiring IV antibiotics pre-operatively in the hospital setting. This means they will have to be fit into an already busy hospital OR schedule, delaying critical time in their care. This will also be a great cost increase to Medicare.

Finally, I have major concerns about the ability to perform these procedures safely and in sterile conditions in the office. A sterile field must be maintained throughout the procedure. Blood and body fluids frequently contaminate the bed, the floor and other items in the room. An office is designed for patient counseling with furniture, chairs, brochures, etc. Because of all these objects in a room used for ?sterile? procedures, I worry about possible contamination to office patients. Most of my patients are women and often they bring their infants and toddlers into the office with them. I do not like the thought a of a 2 year old crawling on the floor 15 minutes after a prostate biopsy or other bloody procedure. Sterilizing equipment in an office with the use of noxious poisons also exposes office patients to unnecessary risks.

I hope CMS does not risk the health and safety of its clients by removing these codes from the ASC list. The obvious costs of this change include 1) delays in care for the ill and elderly patient 2) a decreased standard of care for Medicare patients compared to patients with private insurance (i.e., a double standard) and 3) greater costs to CMS in the long run. What standard of care would you hope for if you were having such a procedure? I hope we can continue to provide the elderly with the excellent level of care they have been receiving.

Sincerely,

Lisa Nipkow Hawes, MD

Submitter : **Dr. Jean-Paul Tran** **Date: 01/26/2005**

Organization : **Dr. Jean-Paul Tran**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a physician,I am writing to oppose the proposed deletions of 81 procedures from the ASC list because they are commonly performed in physician offices. The assumption behind these deletions is that if a procedure is often performed in a physician's office it always can be. This is simply not true. Variations in the following factors affect where a particular physician can perform a particular procedure: the patient characteristics,including co-morbidities,the procedure being performed,the physician office equipment and staffing,the physician's training and experience,the physician's medical liability coverage and state laws and regulations. We urge you to reconsider these 81 deletions and allow those of use performing the procedure to determin the setting best for our patients.
We would also note that much of the support for this appears to be a belief that there will be cost savings from deleting these procedures from the ASC list. However,as physicians we will continue to schedule these procedures in the most appropriate setting. If Medicare will not reimburse ASCs for providing these services when the office is not an appropriate setting,we will perform these procedures in the hospital setting. This will increase Medicare's costs without any benefit to patients. Not only will patients not receive a benefit, but they are likely to have to wait longer to get care as hospitals are not able to schedule these cases promptly.
The rationale for deleting these codes is based on Jan 03 report form HHS OIG. OIG compared payment for procedures in hospital outpatient departments and ASCs and assessed the financial effect of this variance on the Medicare program. OIG analyzed the issue form a strict application of numeric criteria set by CMS for deleting a procedure from the ASC list(20/50 rule). This analysis is from a purely financial point of view for the Medicare program, without an understanding of patient care and health and safety issues. In fact OIG report states that,"we did not evaluate the quality of care provided in these settings or any concerns about access to care." CMS in 1994 proposed these deletions based on 1-26-1995 Federal Register.
Patients with specific urologic abnormalities or concomitant medical conditions are best served in a facility setting that provides a sterile environment, appropriate monitoring, availability of anesthesia,and where there is personnel and equipment for emergency response and follows JCAHO guidelines and recommendations.
There are significant problems with analysis of site-of-service data, and the data collection process is flawed and inaccurate. CMS data does not distinguish based on patient gender, and female cystoscopies skew the site-of-service data. CMS site-of-service data underreports number of procedures furnished in facility settings, because diagnostic cystoscopies are not reported when a therapeutic procedure is furnished in the same operative session. Physicians force to performed procedures at hospitals for patients requiring special care that cannot be provided in an office setting. There is faulty CMS assumptions such as moving procedures to office settings to save money. However,they will then be done at hospitals. Medical offices are not designed to provided conscious sedation and post-sedation monitoring often required for cystoscopy. It is forbidden by many medical liability policies to do conscious sedation in the office setting. State laws preclude certain levels of sedation in the office. ASC sterility is identical to hospital. CPT code 52281 can be very painful and patients need complex anesthesia and specialized equipment. ASC have better outcomes&satisfaction.
The bottom line is that the best way to assure appropriate and cost-effective care for Medicare beneficiaries is to allow the person with the most knowledge of the patient,the procedure and the available setting to choose the site of service. Anything else is a disservice to Medicare beneficiaries.

Issues

Proposed Additions to the list of ASC covered procedures.

CPT 52788 in level 9 with separate reimbursement for the sling material