



American Thoracic Society

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August 29, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1582-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1524-P Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012

Dear Dr. Berwick:

On behalf of the American Thoracic Society (ATS) I want to thank the Centers for Medicare and Medicaid Services for the opportunity to comment on the proposed 2012 Medicare Physician Fee Schedule. The over 15,000 members of the ATS research, prevent treat and cure respiratory, critical care and sleep related illnesses, including Medicare beneficiaries. As such we are deeply interested in the 2012 proposed rule.

The ATS offers the following comments:

Five-Year Review Mandate

The ATS notes with concern CMS's propose to eliminate the 5-year RUC review. While we appreciate CMS's efforts to focus on over-valued codes and recent efforts to survey high volume EM codes, we note the intent of the 5-year review is to ensure systemic appropriate relatively among the entire CPT structure, not merely to address codes that are under or overvalued. We are concerned that losing the 5-year review will eliminate the ability to address system wide inequities in CPT relativity. We especially would like to note the continued unbalance between procedural codes and cognitive services. We believe the majority of advances in addressing the needs of cognitive services have been met in the 5-year RUC reviews.

Should CMS proceed with its proposal to eliminate the 5-year RUC review, despite our reservations, we would appreciate learning how CMS intends to address the persistent inequities between procedural and cognitive services.

Procedure Codes to be Evaluated

The ATS notes that two codes from pulmonary medicine (**94720** Monoxide diffusing capacity (DLCO) and **94240** Residual lung capacity) were included in the list of codes to be surveyed. The ATS recommends these codes be removed from the survey list. We note that both codes have been replaced by subsequent pulmonary function test codes that will be eligible for use starting 2012. The new CPT codes have been approved by AMA CPT and values approved by AMA RUC.

Telehealth Services

Smoking and Tobacco Cessation Counseling

The American Thoracic Society appreciates CMS proposal to add smoking and tobacco cessation counseling codes (**G0436, G0437**) to the list of approved telemedicine services. We believe making these services more widely available through telemedicine services will help improve Medicare beneficiary access and improve overall health. We support this proposal and look forward to its inclusion in the final rule.

TeleICU Services

The American Thoracic Society notes with interest CMS discussion of teleICU services. The American Thoracic Society believes that the existing body of research demonstrates that teleICU services can remotely provide important health services to critically ill patients. However, at this point in time, we agree with CMS's assessment that teleICU services do not yet rise to the level of service or intensity of a face-to-face critical care encounter.

However, we believe the existing G codes suggested by CMS (G0426, G0427, G0406-G0408) do not sufficiently cover the intensity, risk and medical judgment involved in providing teleICU services to critically ill patients. We encourage CMS work with the critical care provider community, telehealth providers and the AMA CPT to develop a more appropriate coding mechanism to capture the level of services offered in teleICU services.

Health Risk Assessment of Annual Wellness

Smoking

The ATS supports the CMS proposal to include life-style questions (smoking, physical activity and nutrition) be included in the health risk assessment (HRA) in the annual wellness visit's (AWV). AWV and HRA should definitely include "smoking" questions in the proposed assessment and the counseling for smoking cessation (separately billable with **99406, 99407**) in subsequent visits.

The ATS notes there are several validated questionnaires to assist providers in asking questions about smoking history and encouraging smoking cessation.

<http://www.chestnet.org/accp/guidelines/tobacco-dependence-treatment-toolkit>

Voluntary End of Life Planning Discussions

The ATS is extremely disappointed that CMS did not propose to add voluntary end of life planning discussion to the list of covered services in the Medicare Annual Wellness Visit.

The medical profession and we as a country do a poor job of assisting patients and their families with dying. Far too often, discussions about quality of life and end-of-life are avoided until it is too late for family members and providers to truly understand the wishes of the patient. Families are left to make difficult decisions with little or no information about the wants of their loved one.

It doesn't have to be this way. The recently revoked Medicare policy would have taken a first step toward encouraging patients and providers to have discussions – in advance – about how Medicare beneficiaries want to manage their care, including end of life care. Despite the claims of the political demagogues, this is not about "death panels". This is about educating Medicare beneficiaries about their choices and helping patients and their loved ones make decisions that are consistent with their personal beliefs and needs. It is also about the provider community understanding and honoring those decisions.

There is ample research to support that advanced care planning works. For example, a randomized trial conducted in Australia, and published in the *British Medical Journal* in 2010, found that advance care planning improves patient and family satisfaction and reduces stress, anxiety, and depression in surviving relatives. Advance care planning also reduced the number of deaths occurring in the technological ICU and increased the chance that the care patients' received was consistent with their preferences.

In addition to research showing the advantages of end of life planning, surveys demonstrate that the American public supports voluntary health of life planning. A national survey conducted by National Journal and the Regence Foundation found that Americans believe strongly that end of life issues should be discussed with providers, that health insurance should cover such voluntary planning and that Medicare should cover end of life planning discussions. Attached is a copy of the survey.

In light of the public's strong support for Medicare coverage, CMS's policy in the 2011 final rule (later rescinded) and the dire need for such discussions with Medicare beneficiaries, the ATS find it very concerning and disappointing that the proposed rule is silent on this issue.

General PQRS Comments

The ATS notes that CMS is proposing to maintain all the existing quality measures from the previous year. The ATS applauds this decision and notes that the quality reporting effort will benefit –both in terms of increased participation and data quality – from the year to year consistency. The time and effort involved in changing quality report systems to accommodate new or deleted quality codes is not insignificant.

The ATS also strongly objects to the call the Congressional mandate penalties for not successfully participating in the PQRS as “payment adjustments.” Such word games played by Congress and CMS staff demean the level of dialogue between providers and the Medicare program and ultimately is a disservice to Medicare beneficiaries.

PQRS Measures Groups

The ATS supports CMS's proposal to adopt the COPD measure group. The ATS also supports the proposal to adopt the sleep apnea measures group. We look forward to CMS moving forward with both these measures groups in the final rule.

The ATS notes with concern that CMS did not propose to accept the pulmonary rehabilitation measure group. We note that the pulmonary rehabilitation measures group was endorsed by the National Quality Forum. While we are disappointed that the pulmonary rehabilitation measures group was not proposed for adoption, we are even more perplexed that CMS provided no discussion of the pulmonary rehabilitation measure was not adopted. Without feedback from CMS, we are left in the dark on how to proceed with this NQF endorsed measure. We note several other NQF endorsed measures were not adopted and not explanation was offered.

We encourage CMS to reconsider is position on the pulmonary rehabilitation measure. We further recommend that CMS provide some feedback to measure sponsors on why measures were not considered ready for adoption. Such feedback will be invaluable in improving the quality measure development and adoption process.

General Quality Comment

The ATS notes that CMS is simultaneously implementing a number of quality related programs, including PQRS, physician compare, Value-based Payment Modifiers, EHR incentive program, eRx incentive program – just to name a few. While the ATS in generally supportive of the quality effort, we note a serious lack of coordinate and integration in all these programs. We are very concerned that providers will be frustrated by the multiple implementation deadlines, lack of clarity and proximity between reporting years and bonuses/penalties, and interactions between programs. Such frustration coupled with anticipated future reductions in Medicare reimbursements expected from future Congressional

budget negotiations could undermine provider faith and participation in the Medicare program. We strongly urge CMS to work to rationalize and better coordinate the multiple quality related Medicare programs.

The ATS appreciates the opportunity to offer these comments. We look forward to seeing how CMS responds to our views in the 2012 Medicare Physician Fee Schedule final rule.

Sincerely,

A handwritten signature in black ink that reads "NS Hill". The signature is written in a cursive, slightly slanted style.

Nicolas S. Hill, MD
President
American Thoracic Society