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September 4, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
P.O. Box 8013
Baltimore, MD 21244-8013.

Attention: CMS-1590-P

Ms. Tavenner:

The American Thoracic Society appreciates the opportunity to comment on the proposed 2013 Medicare Physician Fee Schedule. A significant proportion of the 15,000 members of the American Thoracic Society provide care to Medicare beneficiaries. As such we have a compelling interest in the policies described in the proposed rule. We offer the following comments:

Sustainable Growth Rate Formula

The ATS continues to be frustrated with the inability of Congress and the Administration to develop a permanent solution to the SGR crisis. We can only assume the CMS shares our frustration. While we recognize the steps the Administration has taken to try to ease the situation, and appreciate the extraordinary efforts CMS has taken to make last minute accommodations to Congressional SGR patches, the persistent inability of Congress and the Administration to permanently fix the SGR formula continues to erode provider and beneficiary confidence in the Medicare program. We strongly urge CMS to work with Congress to ensure an equitable permanent solution to the SGR payment crisis.

Pulmonary Rehabilitation Code (G0424)

The American Thoracic Society notes there have been problems with clinical staff time included in G0424 since its inception in 2010. When it first proposed the code for the 2010 rule, CMS cross-walked clinical staff time inputs and practice expense inputs from G0237.

However, G0237 is a time-based code of 15 minutes. G0424 is a time-based code of 60 minutes. CMS originally transferred clinical staff time and practice expense inputs without accounting for the fourfold increase in the time increment. Despite the efforts of the American Thoracic Society and sister organizations to point out this error, the G0424 code moved forward with inappropriately low clinical staff times.

For the 2011 rule, proposed and finalized, CMS increased the clinical staff time by an additional 15 minutes. While the ATS supported the increase in staff time, it still does not fully capture the true staff time involved in providing 60 minutes of pulmonary rehabilitation.

For the 2013 rule, CMS is proposing to transfer 15 minutes of social worker time to 15 minutes of respiratory therapy staff time. The ATS opposes this proposal. Instead the ATS believes strongly that 15 minutes of social worker time should be retained and an additional 15 minutes of respiratory therapy times should be added to the G0424 code, totaling 30 minutes of respiratory therapy time. Adding 15 minutes of staff time will finally address the fourfold clinical staff time difference between G0237 and G0424.

Should CMS proceed with its proposal to reclassify 15 minutes of clinical social worker time to respiratory therapy time, we note the reclassification amounts to a $0.45 cut in the Medicare reimbursement for G0424. Under normal circumstances such a cut of $0.45 would be trivial, however when coupled with substantial cuts in the 2012 final rule, it further erodes the reimbursement for pulmonary rehabilitation services. The ATS is aware of several established pulmonary rehabilitation programs that ceased operations in 2012 primarily in response to lower Medicare reimbursement, which has had an immediate negative impact on beneficiary access. We urge CMS to consider carefully the implications that continued reimbursement cuts will have on Medicare beneficiary access to pulmonary rehabilitation services.

Service Times for IMRT and SMRT

The American Thoracic Society notes with interest the CMS proposed reduction in the services times for IMRT and SMRT. The American Thoracic Society has no opinion on what the appropriate service time for these codes should be.

However, the American Thoracic Society is concerned with the precedent CMS is setting by using data sources outside the RUC survey process to make unilateral adjustments to the service times. The ATS feels strongly that any potentially misvalued codes should be identified through the public comment process and that data should be collected and validated through the RUC survey process. We are concerned that CMS, based on data sources as diverse as patient education websites, the *Washington Post* and the *Wall Street Journal*, is making significant revisions to time values and feel this is ill advised. We are further concerned that episodic incorporation of time data from external sources is likely to undermine the relativity that underpins the current RBRVS system. For these reasons, we strongly urge CMS to address any misvalued codes through the RUC survey process using only approved data sources.

Multiple Procedure Reduction Policy
The ATS opposes extension of the multiple procedure payment reduction (MPPR) policy to the technical component of certain diagnostic cardiovascular and ophthalmology services because CMS's assumptions about potential efficiencies are overstated due to an inaccurate methodology and the codes at issue are not commonly billed together.

Potentially Misvalued Codes Identified in the CY2012 Final Rule – CPT 94762 – continuous overnight pulse oximetry.
The American Thoracic Society agrees with the CMS proposal to address the error in time values associated with 94762. The ATS agrees with the proposal to increase the clinical staff time value to 480 minutes.
However, the ATS would urge CMS to consider raising the time value to 600 minutes to more accurately capture the clinical staff time involved in CPT 94762. ATS notes that practice expense time associated with equipment use is intended to reflect both the time the equipment is in actual use by the patient and any pre- or post-service set up, delivery and maintenance time. This practice also accounts for the fact that the equipment cannot be used for another patient or for providing another service to the same patient during this time period. This methodology in estimating equipment use time is incorporated into the vast majority of CPT codes throughout the fee schedule.

In the case of CPT 94672 (overnight pulse oximetry), the total of 600 minutes encompasses 480 minutes of patient monitoring time and 120 minutes of equipment delivery, set up and take down. The total of 600 minutes is both reasonable, accurate and complies with established procedure for estimating equipment use practice expense times.

94014-6 Patient Recorded Spirometry
The American Thoracic Society supports the addition of physician time of 2 minutes of pre-service evaluation time and 20 minutes of intra-service time in the professional component of CPT 94016 and incorporating these values into the global code 94014. Both have physician work RUV of 0.52 and this would fix the omission of physician time in the global code.

Physician Documentation of Face-to-Face Encounters Performed by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist
The American Thoracic Society sees pros and cons for each of the three proposed options for physician documentation outlined in the proposed rule. We would encourage CMS to allow any of the three proposed options to satisfy the physician documentation of the PA, NP or CNS face-to-face encounter for documentation of DME medical necessity. If forced to choose only one option, the ATS would encourage CMS to consider Option 2. While this option creates additional paperwork, it is the most straightforward and leaves the least amount of room for claims review misinterpretation.

Documentation of Face-to-Face Encounter to the Supplier
The American Thoracic Society notes with interest CMS's proposal to require documentation of

a face-to-face encounter before certain DME equipment prescription orders can be filled. We share CMS's concern with the likely fraud and abuse associated with certain DME products. We chafe somewhat at the requirement that providers who are not engaged in fraudulent or abusive DME practices will be forced to endure additional administrative burdens just to reduce the opportunity for fraud amongst a few bad actors, however we recognize this policy is probably a "necessary evil" to help combat fraud.

The American Thoracic Society strongly recommends against Option 4 which relies on the beneficiary to transmit documentation of a face-to-face encounter for DME equipment. While many beneficiaries would fulfill this role ably, many other beneficiaries would likely not be an efficient conduit of medical documentation. Of the remaining options, the ATS believes Options 2 or 3 most closely resemble current practice and would be the least disruptive options for including transmittal of document from the attesting physician to the DME supplier.

TABLE 24: DME List of Specified Covered Items
The ATS again notes with interest the respiratory related DME products found on the CMS proposed list of DME products requiring documentation of a face-to-face encounter and offers the following comments:

Oxygen – the American Thoracic Society in general agrees that documentation of a face-to-face encounter is appropriate to initiate an order for supplemental oxygen systems (E0424, E0431, E0434, E0439). Further we agree that an annual encounter is probably appropriate for annual renewals. However, requiring documentation of a face-to-face encounter for one-month oxygen refills (E0441, E0442, E0443, E0444) is excessive and counterproductive. Oxygen refill orders should be a follow-up service to the initial oxygen system by the DME provider and should not require separate face-to-face encounters.

Ventilator, respiratory assist devices CPAP/BiPAPand Chest Wall Oscilators– the ATS agrees with the proposal to require face-to-face documentation for ordering ventilators (E0450, E0460, E0463,E0464), respiratory assist devices (E0470, E0471, E0472). CPAP/BiPAP (E0601) and chest wall oscillators (E0483).

Nebulizers – the ATS does not support CMS's proposal to require face-to-face documentation to order nebulizers (00570, E0575, E0580, E0585). Patients with respiratory conditions like asthma or COPD are usually prescribed an inhaler, with or without a spacer, to deliver respiratory medications. For patients who are uncomfortable using inhalers or are not responding as expected to inhaler treatment, it is not unusual for physicians to prescribe nebulizers as an alternate method of administering the medication. The ATS believes strongly that as long as the medical record and underlying diagnosis support the use of a nebulizer, documentation of a face-to-face encounter is unwarranted.

Post-Discharge Transitional Care Management (GXXX1)

The American Thoracic Society appreciates CMS efforts to recognize and reimburse physician work for post discharge care planning and coordination. We agree with CMS that post-hospital discharge represents a significant opportunity for improving Medicare beneficiary care and encourage CMS to support codes that describe the physician work involved in coordinating post hospital discharge care coordination.

The ATS notes that the AMA CPT and AMA RUC are in the process of creating and valuing similar codes that describe the physician work associated with post hospital discharge. The major difference between the CMS created G codes (GXXX1) and the AMA CPT is whether the post discharge E&M visit is bundled into the transitional care coordination code.

ATS participated in weekly conference calls with 15 other specialty associations since the last RUC meeting to prepare for the October RUC meeting survey presentation on both the Transitional Care Management (TCM) and the the Complex Chronic Care Coordination (CCCC) codes. We support comments made by the American Geriatric Society. ATS encourages CMS to value the new RUC-valued codes for CCCC, and add the E/M visit into the TCM codes.

Quality Measures

#57 - Emergency Medicine: Community-Acquired Pneumonia (CAP) – Assessment of Oxygen Saturation
The American Thoracic Society opposes the proposal to retire measure 57 – assessment of oxygen saturation. We believe this measure continues to measure a valuable physician service and is useful in both measuring and improving quality medicine. In 2008, this measure was one of the top 10 reported measures and has been in PQRS/PQRI since inception in July 2007.

#58 - Emergency Medicine: CAP – Assessment of Mental Status
The American Thoracic Society agrees with CMS's proposal to retire this measure.

#59 – Clinical Process/ Effectiveness Emergency Medicine: Community-Acquired Pneumonia (CAP): Empiric Antibiotic
The American Thoracic Society supports the CMS proposal to continue use of the measure 0096/59 –Clinical Process/Effectiveness **Emergency Medicine: Community-Acquired Pneumonia (CAP): Empiric Antibiotic.** However, we note that since the measure was first adopted, new antibiotic drugs have been developed for the treatment of CAP.

It is our understanding that NQF and the American Medical Association have begun discussions about the need to update the measure to reflect recently approved compounds for treating pneumonia. We hope that newer compounds will be added to the measure in the update process.

Should the measure not be updated in a timely fashion, we recommend the listing of antibiotics under this measure be updated to include ceftaroline in the beta lactam class in this measure.

ASTHMA MEASURES GROUP (#53, #64, #231, #232)

#53, #64, #231, #233
The American Thoracic Society again notes that the age ban included in these measures (ages 5-50) effectively excludes a large majority of Medicare beneficiaries. In our comments on the 2012 proposed rule we requested that the age ban for asthma measures be expanded to include patients 65 and older. We again urge CMS to expand the age range for these individual asthma measures to include patients 65 and over. Until the age range is expanded this measure group has very little applicability to the measuring care for Medicare beneficiaries.

COPD and PDE-4 Inhibitors
The American Thoracic Society agrees with the CMS proposal to continue the COPD related quality measures. However we note that a new class of drugs (PDE-4 inhibitors) has been approved to treat COPD since these measures were first developed. We urge CMS to update relevant COPD measures to ensure that PDE-4 inhibitors are added as a potential class of drug to be used in the treatment of COPD.

Pulse Oximetry Equipment Cost
Attached please find an invoice for a pulse oximeter and associated software. We hope this document is useful in support the practice expense associated with pulse oximeters.

We hope the recommendations of the American Thoracic Society will be carefully considered as CMS finalizes the 2013 Medicare Physician Fee Schedule. Please feel free to contact Mr. Gary Ewart (gewart@thoracic.org) or 202-296-9770 if you have questions or need additional information.

Sincerely,

Monica Kraft, MD
President
American Thoracic Society