



*American Journal of Respiratory
and Critical Care Medicine®*

*American Journal of Respiratory
Cell and Molecular Biology®*

*Proceedings of the American
Thoracic Society®*

We help the world breathe®

PULMONARY • CRITICAL CARE • SLEEP

THOMAS W. FERKOL, MD
President

ATUL MALHOTRA, MD
President-Elect

PATRICIA W. FINN, MD
Immediate Past President

DAVID GOZAL, MD
Vice President

MARC MOSS, MD
Secretary-Treasurer

National Headquarters
25 Broadway, 18th Floor
New York, NY 10004
P. (212) 315 - 8600
F. (212) 315 - 6498

STEPHEN C. CRANE, PhD,
MPH
Executive Director

GARY EWART
Senior Director
Government Relations

NUALA MOORE
Senior Legislative
Representative
Government Relations

FRAN DU MELLE
Director
International Programs
& Activities

Washington Office
1150 18th Street, N.W.
Suite 300
Washington, D.C. 20036
P. (202) 296 - 9770
F. (202) 296 - 9776
www.thoracic.org

September 2, 2014

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

RE: **CMS-1612-P**

Administrator Tavenner:

On behalf of the 15,000 members of the American Thoracic Society (ATS), we offer our comments on the 2015 proposed Medicare Physician Fee Schedule. The ATS is medical professional association dedicated to the prevention, detection, treatment and cure of respiratory disease, critical care illness and sleep disordered breathing. The ATS pursues its mission through education, research and advocacy. Many of our members treat Medicare beneficiaries. As such, we have a keen interest in the proposed polices impacting the Medicare program. 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.

The significantly revised cost estimate for fixing the SGR seems to have generated genuine legislative interest from Congress. Both legislative chambers appear to have adopted a similar approach to resolving the SGR crisis. While the initial legislative activity is encouraging, we fear that the overall contentious atmosphere in Congress may prevent SGR legislation from fruition. We strongly urge CMS to work with Congress to ensure an equitable permanent solution to the SGR payment crisis.

Sleep Practice Expense

The ATS concurs with CMS's proposal to transition from film practice expense cost to digital for several families of codes. The AMA RUC Practice Expense Subcommittee Migration first put this proposal forward from Film to Digital Imaging Workgroup.

While we support CMS's effort we are concerned that CMS is proposing to use the practice expense cost of a desk top computer (ED021) in place of a PACS workstation. The ATS believes using the practice expense from a desk top computer will significantly under value the actual physician costs associated with a PACS work station.

The ATS also agrees with the comments of the American Medical Association RUC regarding presenting practice expense data in a transparent way. The ATS concurs the AMA RUCs comments:

Upon review of the example provided with the supporting data files, the RUC is concerned that when all codes with direct PE inputs are included, the file would be too large to realistically implement. In addition, this approach does not take into account the supporting materials submitted with the practice expense spreadsheets that provide rationale for clinical labor activities that have times which differ from PE standards or explain the allocation of equipment minutes. The RUC is concerned that the format would be unwieldy and unsustainable. As an alternate, more feasible approach, the RUC recommends that CMS posts all practice expense spreadsheets and supporting materials in code order on its website. The RUC reiterates that is it very much in support of transparency and accuracy. We are happy to work with CMS to develop other options to make the breakdown of clinical labor time available in the direct PE input database and devise a more manageable solution to the problem.

The ATS urges CMS to closely consider AMA RUC's recommendation on practice expense data transparency.

Inclusion of Capnography for Pediatric Polysomnography

The ATS supports CMS's proposal to include the cost of the capnography equipment into pediatric polysomnography. We appreciate CMS's willingness to add the cost of this essential equipment into the practice expense costs and we agree with the proposed price of \$4,534.23. We believe that including capnography into the practice expense costs will more accurately capture the appropriate costs of this service.

OPPS and ASC Rates for Developing PE RVUS

The ATS is pleased that CMS is abandoning its proposal to use OPPS and ASC values to establish PE values in the Medicare Physician Fee Schedule. As outlined in our comments on the 2014 proposed Medicare Physician Fee Scheduled rule, we believe such a policy is unjustified. The ATS does agree with using hospital practice expense costs as a point of comparison for physician fee schedule practice expense costs to identify potentially misvalued codes. However, the identification of a practice expense cost anomaly between hospital and physician fee schedule should not lead to an automatic payment adjustment, but rather should be used to identify codes that need to be resurveyed to support and potentially adjust practice expense costs.

Modifier to Track Hospital Owned Physician Practice Billing

We understand that CMS is also proposing to implement a new HCPCS modifier for providers to report with every code for physician and hospital services furnished in an off-campus, provider-based department of a hospital. While ATS supports the collection of this data in order to ensure accurate and appropriate payment rates across different settings, we believe there are less burdensome methods that would capture the same information. For example, CMS can readily obtain this information through place of service indicators or on facility addresses instead of creating a new HCPCS modifier. Should CMS require a mechanism on the claim an alternative to a modifier would be to model against a check box on the claim for purchased services.

Potentially Misvalued Codes CPT 94010

The ATS appreciates CMS's continuing efforts to identify potentially misvalued codes, particularly those codes with high volumes. The proposed rule identifies one such high volume code used in pulmonary medicine – 94010 – breathing capacity test. The ATS recognizes that 94010 meets the criteria for a potentially misvalued codes. It is our strong belief that the physician work value for the code has not changed over time, but that practice expense inputs likely have evolved. To this end, the ATS has developed action plans that it has submitted to AMA RUC to survey only the practice expense values for this code in the coming year. The ATS believes our survey action plan will collect the needed data to appropriately value this code going forward.

Chronic Care Management and Chronic Disease Management

The ATS notes with great interest CMS's proposal on chronic care management and chronic disease management. In brief, we believe CMS's proposal fails to recognize the important differences between chronic care management and chronic disease management. Chronic disease management refers to treating patients with chronic diseases by largely adhering to established treatment guidelines. Chronic care management refers to patients who cannot be treated using standardized guidelines, typically because their clinical condition is atypically complex.

The ATS has been working closely with sister organizations to develop a consensus in the medical community on how CMS should proceed with chronic disease management and chronic care management. In separate comments, the ATS and several of our sister organizations make specific recommendations on how CMS should proceed with implementing G codes for chronic care and disease management. The ATS urges CMS to carefully consider these consensus comments from the physician community.

Changes to Sunshine Reporting Provisions

The ATS is extremely concerned that CMS is proposing to eliminate the Sunshine reporting exemption for ACCME accredited educational events. We recognize that CMS feels it is inappropriate for its regulatory policy to specifically articulate which accrediting agencies earn the exemption (and by exclusion, which don't). While we understand CMS's reluctance to review every accrediting bodies request for inclusion in the reporting exemptions, we disagree with CMS's position that eliminating the ACCME reporting exemption will have minimal impact on educational product providers because they can still meet the third party transfer payment reporting exemption.

As currently drafted, the third party payment reporting exemption applies only when the industry providing the funds a) does not select the presented content b) does not select the speaker or list of potential speakers and 3) is unaware of who the speakers and attendees of the event are both prior to the event and for a time period after the event. The ATS strongly agrees and complies with requirements a) and b), but notes the requirement c) is very impractical in the real world. The ATS offers a range of ACCME accredited educational offerings at our annual meeting. Several of these offerings receive industry support. The industry support complies with all ACCME requirements. However, the event is public, the speakers for each session are publicly displayed and attendance is open to all people who register for the event – including industry attendees at our meeting. Hence it is impossible to keep the identity of speakers and event attendee's secret from industry sponsors after the event has been organized.

If CMS proceeds with its proposed policy and does not address the problems with third party transfer reporting exemption requirements, it will have a significant negative impact on continuing medical education offerings.

The ATS supports the proposed revision to the third party transfer reporting exemption developed by the American Medical Association. This proposed revision is supported by several sister physician societies.

Specifically, the ATS and our colleagues urge CMS to slightly modify the proposal to add the language that the exemption applies under section 403.904(i)(1) when an applicable manufacturer provides funding to a CE provider, but does not select or pay the covered recipient speaker/faculty directly, or provide the CE provider with a distinct, identifiable set of covered recipients to be considered as speakers/faculty for the CE program. The agency can include the guidance in the regulation or preamble that the foregoing is achieved where the industry donor is unaware of the speakers/faculty and other participants before committing to fund the activity under section 403.904(i)(1). This accomplishes CMS' goal while eliminating the potential for negatively impacting CE. To allow CE providers time to ensure that their processes comply with the modified exemption, we urge CMS to make this change effective six months after the final rule is issued.

The ATS also joins the AMA and our sister organizations in urging CMS to reconsider its decision not to cover medical textbooks, journal article supplements, and reprints within the existing statutory exclusion for educational materials that directly benefit patients.

Physician Quality Measures

The ATS notes that CMS is proposing to retire two COPD-related physician quality reporting measures (COPD: Spirometry Evaluation and COPD Inhaled Bronchodilator Therapy) and the COPD Measure Group due to lack of a measure sponsor. The ATS is pleased to report it has reached an agreement with AMA PCPI and will assume sponsorship of the two COPD individual measures. Our sponsorship and upkeep of these measures should allow CMS to continue has this two individual measures and continue the COPD Measures Group for 2015 and beyond.

CPT/RUC Time Line

The ATS notes with interest CMS's proposal to change the timeline for considering and accepting new and revised CPT codes and valuations. We agree with the spirit of CMS's desire to improve the responsiveness and transparency of the CPT editing and valuation process. However, we feel the specific changes recommended by CMS do not meet its stated objective. The ATS and several other organizations joined the American Medical Association in a coalition letter outlining our recommendations to improve the timeliness and transparency of the CPT process. We encourage CMS to adopt the recommendations outlined in that letter. The ATS appreciates the time and effort CMS staff put into drafting proposed rules and the considerable effort CMS staff put into reading and evaluating public comments. We hope our comments will assist CMS in its efforts to continue to efficiently manage the Medicare program and ensure that safe, effective and quality medical care is offered to all Medicare beneficiaries.

Sincerely,



Thomas Ferkol, MD
President, American Thoracic Society