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Via Electronic Submission

September 2, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1612-P
Room 445-G, Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: CMS-1612-P – Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2015

Dear Administrator Tavenner,

I am pleased to submit these comments on behalf of the American Society of Clinical Oncology (ASCO) in response to the recent Proposed Rule for the Medicare Physician Fee Schedule (MPFS) for Calendar Year (CY) 2015 (79 Federal Register 40318, July 11, 2014).

ASCO is the national organization representing over 35,000 physicians and other healthcare professionals specializing in cancer treatment, diagnosis, and prevention. ASCO members also are dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for prevention, diagnosis, and treatment of cancer are available to all Americans, including Medicare beneficiaries. We appreciate the opportunity to comment on the policies that CMS is proposing for 2015.

ASCO provides the following recommendations, which are summarized below and discussed in greater detail in subsequent sections of this letter.

<u>Potentially Misvalued Codes</u>

CMS should remove the drug administration codes from the list of potentially misvalued CPT codes.

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- CMS should implement its proposal to permit greater opportunity for public comment on the relative value units assigned to CPT codes, but CMS should not implement the new timeline and procedures until the CPT 2017 cycle and the 2017 Medicare physician payment schedule.

Using OPPS and ASC Rates in Developing PE RVUs

- CMS should exercise caution when examining the use of various data sets for use in refining future Medicare payment rates.

Quality Measurement and Reporting through QCDRs and PQRS

- CMS should avoid exacerbating the inadequacies of PQRS measures in oncology.

- ASCO urges CMS to promote group reporting through qualified clinical data registries (QCDRs).

- Before CMS requires providers to report additional outcomes measures, CMS should allow time for ASCO and the cancer community to develop oncology-focused outcome measures for QCDR reporting.

- CMS should expand the use of specialty-focused measures to promote quality of care in oncology.

- The agency should promote positive reporting practices by revising the QCDR designation timeline.

Value-Based Modifier Program

- CMS should continue efforts to integrate QCDRs fully within the value-based modifier program.

- CMS should finalize the proposal to protect small practices from downside risk under the value-based modifier program.

- CMS should exclude Part B drugs from the cost measure for the value-based modifier program. The specialty adjustment factor fails to ensure a reasonable and fair system for oncologists prescribing cancer drug treatment regimens, and this problem is exacerbated by the exclusion of Part D drug costs.

Public Reporting of Quality Measures and Physician Compare

- ASCO urges CMS to finalize the proposal to provide options to QCDRs on public reporting of QCDR data.

- CMS should delay mandatory public reporting of QCDR data.

- The agency should refrain from creating an oncology composite score to be posted on Physician Compare that is based on PQRS measures.

Chronic Care Management

- CMS should permit more than one physician to receive payment for complex chronic care management services within a 90-day period.

Open Payments/Sunshine Initiative

- We urge CMS to retain the explicit exemption for continuing education under the Open Payments program.

Sustainable Growth Rate (SGR)

- CMS should work with Congress to secure a permanent solution for replacing the sustainable growth rate formula.

Radiation Oncology

- CMS should continue to use the costs of radiation treatment vaults as a direct cost input.

Imaging

- CMS should collect and use accurate, comprehensive data before proceeding with plans to update the direct practice expense inputs for imaging services, including mammography.

Creation of Obesity Counseling Codes in Group Setting

- CMS should recognize obesity counseling services provided by oncologists.

These recommendations are discussed in greater detail below.

Potentially Misvalued Codes

CMS Should Remove the Drug Administration Codes from the List of Potentially Misvalued CPT Codes.

In this proposed rule, CMS identified four drug administration codes as potentially misvalued. Those four CPT® codes are 96372, 96375, 96401 and 96409.[1] However, we strongly disagree with the conclusion that these relative value units (RVUs) for these codes are potentially misvalued. There have been no meaningful changes in technology or cancer care since 2004 that would suggest the need for any meaningful change in the work or practice expense RVUs assigned to these codes.

In fact, when a related set of codes (96413, 96415, 96417, 96365, 96366, 96367 and 96368) underwent review by the American Medical Association's RVU Update Committee (RUC) in January 2013, the RUC did not recommend any changes in the work RVUs. Surveys are an expensive and time consuming endeavor, and we strongly believe that the time and expense to re-value these codes will yield little value as exampled by the previous 2013 review of drug administration codes.

We would welcome the opportunity to meet with CMS officials and discuss these issues in greater detail. In the interim, we urge CMS to remove these administration codes from the list of potentially misvalued codes.

CMS Should Implement its Proposal to Permit Greater Opportunity for Public Comment on the Relative Value Units Assigned to CPT Codes, But CMS Should Not Implement the New Timeline and Procedures Until the CPT 2017 Cycle and the 2017 Medicare Physician Payment Schedule.

We support the changes CMS has proposed for the annual RVU review of CPT codes. For future years CMS is proposing to adjust the process to allow for greater opportunity for public input prior to implementation of new CPT codes. This is preferable to the current method of finalizing RVU values on an interim basis in each year's final rule.

We commend CMS for recognizing the need to enhance the transparency of the rate-setting process. Stakeholders should be afforded the opportunity to provide input to CMS before any revisions to reimbursement rates assigned to specific codes become effective. By permitting a notice and comment period before any changes to reimbursement rates for revised or potentially misvalued codes become effective, CMS would be able to thoroughly vet stakeholder concerns from a policy perspective and identify any methodological and/or data errors before revisions are put in place. The proposed enhancement to the rate-setting process is all the more necessary now that CMS reviews work RVUs continually in conjunction with routine assessments of potentially misvalued codes and overrules a substantial number of RUC recommendations.

However, caution is warranted because CMS has proposed to create HCPCS G-codes for the instances in which CPT codes changes occur without the opportunity for valuation review under

[1] CPT Descriptions are copyright of the American Medical Association. 96372 - Therapeutic, prophylactic, or diagnostic injection; 96375 - Therapeutic, prophylactic, or diagnostic injection, each additional sequential intravenous push of a new substance/drug ; 96401 - Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic; 96409 - Chemotherapy administration; intravenous, push technique, single or initial substance/drug.

the proposed revised system. The creation of additional G codes could cause confusion among coders, billers and providers when reporting services rendered. The additional G codes could also create undue administrative burden for various stakeholders by creating additional work within the claims adjudication process and possible claims re-filing. We support the proposal set forth by the American Medical Association (AMA) that would help alleviate the need for G-codes, and we urge CMS to work with the AMA to implement this proposal.

CMS has proposed to implement the proposed procedural changes in time for the rulemaking for CY 2016. However, this would significantly delay the implementation of some code proposals that already are under consideration. Instead of implementing these changes for CY 2016, we urge CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare physician payment schedule.

Using OPPS and ASC Rates in Developing PE RVUs

CMS Should Exercise Caution When Examining the Use of Various Data Sets for Refining Future Medicare Payment Rates.

CMS is exploring ways to collect information from professionals or other sources with the hope of improving the valuation of services under the physician fee schedule and other settings of care. In this notice of proposed rulemaking, CMS does not embrace any specific policy change or specific source for code valuation information. CMS proposes to use a new modifier to collect claims information for tracking services provided in off-campus locations of hospital outpatient departments.

The delivery of oncology services is particularly complex, and it is critically important for policymakers to have a comprehensive understanding of the way individuals obtain care in our cancer system before adopting any new data sources that might alter the reimbursement landscape for oncology care. Individuals with cancer obtain medically necessary services from a complex combination of practice settings, payers and funding sources. These services include, but are not limited to, education and counseling related to genetic testing for cancer genes, nutrition services, nurse navigation services, and social services. Taking an oversimplified view could easily result in an "apples" to "oranges" comparison that undermines access to cancer care and potentially exacerbates disparities in care. Misapplying data to justify reductions in reimbursement could have significant, adverse impacts on a particularly vulnerable group of patients.

ASCO has established a special task force to explore site of service issues and make recommendations on how best to protect the interests of individuals with cancer, including Medicare beneficiaries, Medicaid enrollees and dual eligibles. We look forward to sharing our findings with CMS in the future.

Quality Measurement and Reporting through QCDRs and PQRS

ASCO operates the Quality Oncology Practice Initiative (QOPI), which CMS has approved to

serve as both a Qualified Clinical Data Registry (QCDR) and a registry for reporting measures under the Physician Quality Reporting System (PQRS). Traditional QOPI and QOPI Certification are the leading quality measurement and quality assurance programs for outpatient medical oncology care. Whereas oncology-focused quality measures are severely limited under programs such as PQRS, QOPI offers more than 160 quality measures that span multiple domains of cancer care, including disease-specific measures. With over a decade of experience, the QOPI measures are continuously tested, refined and updated to reflect the evolving scientific evidence and published care recommendations.

ASCO commends CMS for its efforts to align the use of QCDRs within the PQRS, the Value-Based Payment Modifier (VM) and Physician Compare. We see additional opportunities for CMS to amend these programs to further the interests of Medicare beneficiaries and the Medicare program, and we raise specific issues related to these points within our comments below.

CMS should Avoid Exacerbating the Inadequacies of PQRS Measures for Oncology.

PQRS lacks the number and types of quality measures to promote quality and value in oncology care. ASCO's volunteers and staff would be pleased to collaborate with CMS to help add additional oncology-focused measures to PQRS that help promote high-quality, high-value cancer care.

In the absence of adequate oncology measures under PQRS, adding PQRS reporting requirements threatens to exacerbate the administrative burdens for oncology practices without creating meaningful benefits for either the Medicare program or its beneficiaries. Such increases in administrative burdens are counterproductive – siphoning away resources from oncology practices that could otherwise be focused on the needs of individuals with cancer.

In light of the fact that the measures available under PQRS are insufficient for oncology care, we urge CMS to —

- Preserve the cancer stage documentation measure as part of the oncology measures group. CMS proposes to eliminate the cancer stage documentation measure from the oncology measures group. This proposal was made without explanation in the proposed rule. We believe that documenting a patient's cancer stage is a critical step in treatment planning and is the standard in the vast majority of cancer cases. In addition, cancer staging is critical data that contributes significantly to the robustness of the Medicare-SEER database. PQRS currently lacks the number and types of quality measures necessary to adequately promote patient interests even though the elderly population served by Medicare has the highest incidence of cancer of any age group. CMS should not finalize its proposal to eliminate this quality measure from the oncology measures group.

- Revisit the decision finalized last year to increase the number of PQRS measures that oncologists and other providers must report from three to nine.

- Revisit the decision finalized last year to require reporting of PQRS measures from at least three National Quality Strategy domains. For cancer care specialists, these requirements simply add administrative burdens without the potential to improve the care of individuals with cancer.

ASCO urges CMS to Promote Group Reporting through QCDRs.

CMS should establish a pathway for group reporting through QCDRs that is similar to the group practice reporting option (GPRO) currently available within PQRS. In our experience operating the leading clinical data registry for oncology (QOPI) over the past decade, group reporting of quality measures promotes communication, collaboration, and system and process changes that support sustained improvements within group practices. In fact, most oncology practices function as groups with shared responsibility for patient care by multiple eligible providers. Group reporting provides information that is highly relevant to modern cancer care system.

In addition, group reporting successfully addresses the critical issue of denominator size for quality measures. This is an especially important consideration in oncology because small sample sizes are common. This is due in part to the fact that oncology encompasses over 100 different types of disease, and the treatment of cancer often differs based on both the type and stage of the individual's disease.

Unfortunately, ASCO was forced to change QOPI's well-established group reporting methodology to gain designation as a QCDR for 2014 – despite significant evidence demonstrating the advantages of group reporting. Now that CMS has experience with QCDRs, we urge CMS to take immediate steps to permit group reporting for 2015 that takes advantage of the opportunities presented by group reporting through QCDRs.

Before CMS Requires Providers to Report Additional Outcome Measures, CMS Should Allow Time for ASCO and the Cancer Community to Develop Oncology-Focused Outcome Measures for QCDR Reporting.

CMS should not finalize its proposal to increase the number of outcome measures that eligible professionals are required to report to a QCDR from one to three. Although we strongly agree with CMS that the measures used by QCDRs should be robust and meaningful, the proposed emphasis on outcome measures is premature in oncology. Traditional outcome measures for cancer care are highly variable and particularly burdensome to track and report across providers and settings. The timeframes for outcome measures in cancer often do not fit squarely within an annual cycle. ASCO is committed to developing oncology-focused outcome measures for use by QCDRs, but currently, adequate outcome measures for oncology do not exist under private or public reporting programs such as PQRS.

When developing outcomes measures for oncology, we urge the agency to place significant weight on patient autonomy and the decisions that individuals with cancer make regarding whether and how to pursue various treatment options. One readily measurable outcome would be whether or not cancer patients have completed an advanced directive for maximal care to help

ensure that each individual can effectively communicate their personal wishes to the oncology team.

Before CMS requires providers to report additional outcome measures, CMS should allow time for ASCO and the cancer community to develop and test oncology-focused outcome measures for QCDR reporting. If implemented in CY 2015, the proposal to mandate the collection of additional outcome measures by QCDRs would be premature and counterproductive in oncology, undermining efforts to promote quality and value in cancer care.

CMS Should Expand the Use of Specialty-Focused Measures to Promote Quality of Care in Oncology.

We commend CMS for increasing the number of non-PQRS measures that QCDRs may incorporate, and we encourage the agency to continue to allow the introduction of additional non-PQRS measures into QCDRs. CMS should continue to expand the number of non-PQRS measures integrated into QCDRs so that eligible professionals may choose from a robust set of quality measures that are most appropriate for their scope of practice to satisfy their quality reporting obligations. Congress enacted the provision authorizing QCDRs in 2012 so that Medicare could harness the strengths and specialty-focused expertise of independent registries to provide alternatives to programs established by CMS such as PQRS. CMS should embrace the use of as many non-PQRS quality measures as possible to ensure that QCDRs achieve their full potential for quality improvement. QOPI includes more than 160 oncology-specific measures, but the current limitations on the number of reportable non-PQRS measures hamper the Medicare program's ability to fully benefit from QCDRs like QOPI.

The Agency Should Promote Positive Reporting Practices by Revising the QCDR Designation Timeline.

We strongly urge CMS to ensure that providers know at least six months in advance whether an entity is designated or re-designated by CMS to serve as a QCDR for the upcoming reporting year. Under the current system, QCDRs must seek re-designation each year, and these determinations may not be announced by CMS until after the beginning of the reporting year. This timeframe encourages providers to wait on reporting data to their chosen QCDR until they receive confirmation that the QCDR is designated to report data to CMS. The agency should explore options that will minimize disruptions in reporting and ultimately facilitate continuous reporting and potential quality improvement gains. As CMS takes steps to facilitate more frequent data submissions throughout the year, we urge CMS to adjust the timing of QCDR designations and/or establish multi-year designations.

Value-Based Modifier Program

CMS Should Continue Efforts to Integrate QCDRs Fully within the Value-Based Modifier Program.

ASCO supports the efforts by CMS to continue integrating QCDRs into the VM quality-tiering

methodology. QCDRs offer an important advantage over traditional PQRS because QCDRs allow providers to select measures that are appropriate to their day-to-day practices. This focused approach will help ensure that the value-based modifier program serves the interests of patients and that oncologists and other specialty providers are held accountable to the standards of their specialty practice rather than measures more applicable to general practitioners or other specialties.

CMS Should Finalize the Proposal to Protect Small Practices from Downside Risk under the Value-Based Modifier Program.

For 2015, CMS continues to implement the VM program by expanding the VM to group practices with between 2 and 9 eligible professionals and solo practitioners. ASCO supports the CMS proposal to limit the risk of a downward VM adjustment in the 2017 adjustment period to only practices with more than 10 eligible professionals. Given the important role that small oncology practices play in providing access to patients throughout the United States, as well as the significant administrative burdens and financial pressures on these practices, CMS should limit the downside risk for these small practices for several years.

CMS Should Exclude Part B Drugs from the Cost Measure for the Value-Based Modifier Program. The Specialty Adjustment Factor Fails to Ensure a Reasonable and Fair System for Oncologists Prescribing Cancer Drug Treatment Regimens, and This Problem is Exacerbated by the Exclusion of Part D Drug Costs.

CMS continues to propose including Part B drug expenditures within the Medicare Spending per Beneficiary measure used in the cost composite for the value-based modifier. This decision is likely to provide information that is confusing or misleading for patients and that unfairly disadvantage medical oncologists who specialize in treating individuals with complex anticancer drug regimens that are typically covered under the Medicare Part B benefit.

CMS should take steps in the final rule to ensure that cancer patients are not misled and that medical oncologists will be treated fairly when the data collected in 2014 and 2015 is used to adjust future payment levels. The most straightforward approach would be to remove Part B drugs from these calculations until a more reasonable and fair system can be implemented. CMS must avoid creating perverse incentives under the Medicare program that penalize providers who are willing to treat individuals with complex forms of cancer and other life-threatening illnesses.

The information presented in the proposed and final notices for CY 2014 leave significant doubt that the specialty adjustment factor proposed by CMS will provide a fair and reasonable safeguard for oncologists who treat individuals requiring anticancer drug regimens. The potential for significant distortions is further highlighted by the Agency's proposal to continue excluding Part D drugs from the Medicare Spending per Beneficiary cost measure because of administrative complexities. Oncologists that provide high-quality and cost-effective care can be expected to prescribe and administer a significant number of Part B drugs in their day-to-day practice. Under the CMS proposal, significant financial ramifications may arise on the basis of measures that exclude many of the drugs prescribed by other physician specialties but that

include the Part B drugs commonly administered by oncologists. Until CMS can develop a system that accounts fairly for all drug costs incurred under Medicare, CMS should exclude all drug expenditures from the Medicare Spending per Beneficiary cost measure.

Public Reporting of Quality Data and Physician Compare

ASCO Urges CMS to Finalize the Proposal to Provide Options to QCDRs on Public Reporting of QCDR Data.

We support CMS' proposal to provide QCDRs with the latitude to determine the most appropriate location and presentation of data for public disclosure to meet the needs of Medicare beneficiaries. QCDRs are in the best position to ensure that the information is presented to the public in a manner that is clear and relevant to all audiences. Empowering QCDRs to choose the best location will serve the interests of the Medicare program in a manner that is administratively feasible for the agency and that avoids confusion among the public. For QCDRs that opt to provide public access to this information through their own website, this will provide an opportunity to make the disclosures more valuable to the public by including explanatory information that places the data into context.

CMS Should Delay Mandatory Reporting of QCDR Data.

The initiative to integrate QCDRs into the Medicare program is still young, and most stakeholders anticipate that a number of new QCDRs will be developed and approved in the near future. Given the vast array of practical and technical challenges associated with operating a new QCDR, we urge CMS to delay the added complications of any mandatory public reporting requirements for QCDRs for several years.

We understand and embrace the need for transparency and public reporting, but this must be balanced against the administrative burdens that otherwise exist for QCDRs, and this aggregate burden should be reflected in CMS' implementation schedule. If mandatory reporting is eventually implemented, there should be significant safeguards in place to ensure that the information available to Medicare beneficiaries is accurate and provided within context. There should be a review period of no less than 120 days, an opportunity for individual and group providers to submit comments, and a resolution process.

The Agency Should Refrain from Creating an Oncology Composite Score to be Posted on Physician Compare that is Based on PQRS Measures.

Introducing transparency and evaluating providers on the quality of care provided are both important to reinventing the Medicare program, but ASCO has concerns over the agency's decision to seek comments on the creation of a composite oncology measure. Oncology practice is complex and existing federal quality measurement programs like PQRS do not reflect the day-to-day practice of delivering cancer care for Medicare beneficiaries.

ASCO is prepared to work with CMS to develop and pilot test potential approaches to composite

scoring for oncology. If the contemplated composite measure is based on PQRS measures, it would have the potential to mislead beneficiaries about the perceived quality of oncology providers. Developing a meaningful composite score for oncology would require careful analysis of weighting, reliability and statistical considerations. CMS should forgo creating composite measures that are based on individual existing PQRS reporting measures and posting such on Physician Compare.

Chronic Care Management

CMS Should Permit More Than One Physician to Receive Payment for Complex Chronic Care Management Services within a 90-Day Period.

ASCO continues to support CMS efforts to develop and implement services that encourage care coordination for patients with complex clinical conditions. As CMS noted in the 2013 proposed rule (77 Fed. Reg. at 45005), oncologists are among the three leading specialties (primary care, oncology and rheumatology) with the greatest percentage of physicians directing care. We support the agency's decision to continue allowing the delivery of complex chronic care management services (CCM) by physicians practicing within any medical specialty. This recognizes the important role that oncologists and other specialties play in coordinating patient care.

However, CMS should amend its policies concerning the CCM G-code to permit more than one physician to bill for this code within each 90-day period. This current policy creates confusion and unfairness when more than one physician is providing complex chronic care management services within the same time period. In many instances, the care of individuals with cancer is extremely complex, including the management of multiple comorbidities that require input from multiple physicians. The current CMS policy that limits payment for CCM services does not ensure that the most appropriate physician is receiving reimbursement for the services. The current policy encourages providers to race to bill, which may prevent Medicare beneficiaries from receiving the complete positive benefits associated with CCM services. In situations where more than one physician or qualified health care professional provides all the required services, they should receive reimbursement under the CCM G-code.

Open Payments/Sunshine Initiative

We Urge CMS to Retain the Explicit Exemption for Continuing Education under the Open Payments Program.

We strongly disagree with CMS' proposal to remove the explicit exemption that exists for accredited or certified continuing education (CE). CMS states that there is redundancy in the existing regulations and the explicit exemption for CE is addressed under a more general exemption. However, the current exemption is working well, and the proposed change will create unnecessary ambiguity and confusion. The proposed change would have an undesirable chilling effect on physician participation in accredited education program as both speakers and learners. Ultimately, this would have an adverse impact on the quality of patient care.

ASCO is providing additional comments on this topic in a separate letter to CMS.

Sustainable Growth Rate

CMS Should Work with Congress to Secure a Permanent Solution for Replacing the Sustainable Growth Rate Formula.

We are once again concerned about the lack of a permanent solution to eliminate the sustainable growth rate (SGR) formula. Congress again enacted an imperfect temporary measure to avert unsustainable cuts to physician reimbursement in the Protecting Access to Medicare Act of 2014. The SGR patch is set to expire again on March 31, 2015. As payment cuts continue to loom over physicians, we are concerned that many physicians will opt out of participation in the Medicare program and decrease access for Medicare beneficiaries. We urge CMS to work with Congress to develop and implement a permanent solution to the SGR problem that will maintain payment rates for physicians and provide stability to the Medicare program.

Radiation Oncology

CMS Should Continue to Use the Costs of Radiation Treatment Vaults as a Direct Cost Input.

CMS should not finalize its proposal to remove the radiation treatment vault as a direct cost input for radiation treatment codes. This proposed policy would result in significant cuts to these codes, and as a result, create significant and immediate aggregate drops in reimbursement for facilities that serve as key patient access points for radiation oncology treatments.

The vault warrants classification as a direct cost for multiple reasons. Radiation treatment vaults are precisely calibrated and physically linked to the specific piece of radiation equipment it houses, serving to protect health care professionals, caregivers and others from such radiation. Radiation treatment technology must be housed in a vault tailored to the specific type of technology used. The vault serves a unique medical need as it is a required part of safely delivering radiation treatments. The costs of a radiation treatment vault (including shielding, electrical, plumbing, and other specifications) are unique to the vault itself and not attributable to the building. Land lease contracts typically require the removal of a vault when a radiation therapy facility's lease expires to return the facility back to standard medical office space.

At a minimum, additional time for agency review and evaluation of the nuances associated with this determination are necessary. The situation is further complicated by the fact that the affected codes are also under review by the American Medical Association's RVU Updated Committee, but there will be no opportunity for public comment on these codes prior to the publication of the final rule for CY 2015. At a minimum, CMS should not implement dramatic changes to the treatment of vault expenses until there is an opportunity for public notice and comment on the potential changes to the reimbursement for other radiation oncology services. The adverse impacts of rushing to implement this policy are stark, as removal of the vault as a

direct cost input effectively eliminates Medicare reimbursement for critical aspect of delivering radiation treatment for oncology patients. We urge CMS to refrain from finalizing this proposal.

Imaging

CMS Should Collect and Use Accurate, Comprehensive Data before Proceeding with Plans to Update the Direct Practice Expense Inputs for Imaging Services, including Mammagraphy.

CMS is working to update the practice expense inputs for a number of imaging procedures to reflect the transition from film to digital formats. As one example, CMS proposes to allocate minutes for a desktop computer (ED021) as a proxy for the costs of the Picture Archiving and Communication System (PACS) workstations often used to furnish digital imaging services. This particular comparison is flawed and would undervalue the costs of providing these services. We urge CMS to take the time to collect data that reflects the full costs of operating digital systems, and we also urge CMS to review various imaging services on a case-by-case basis to determine whether or not migration to digital formats is commonplace.

Of obvious concern to the cancer community is ensuring that individuals continue to have widespread access to high-quality mammography services. As part of the overall transition of imaging inputs from film to digital, CMS is proposing to consolidate all mammography services under the existing CPT codes for film mammography. We support the CMS proposal to assign the relative value units for digital mammography to these codes, and we urge CMS to proceed cautiously moving forward to ensure that the reimbursement levels for all types of mammography are adequate and help promote patient access.

Creation of Obesity Counseling Codes in Group Setting

CMS Should Recognize Obesity Counseling Services Provided by Oncologists.

ASCO supports the agency's proposal to create two new HCPCS codes for the reporting and payment of group behavioral counseling for obesity. Obesity counseling services are currently covered by CMS in the primary care setting which is defined in the national coverage determination as, "one in which there is a provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." ASCO requests that the agency to extend the recognition of obesity counseling services to the oncology setting as there is increasing evidence linking obesity to the elevated risk of cancer, the recurrence of cancer and to cancer-related mortality in individuals diagnosed with early-stage disease as supported in the recently published provider guide on Obesity and Cancer published by ASCO (www.asco.org/obesity).

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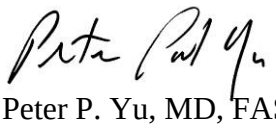
Thank you for the opportunity to provide these comments. ASCO is committed to working with CMS to help ensure the Medicare program can meet the needs of its beneficiaries with cancer now and in the future. We look forward to working with you on these important issues. Please contact Julia Tomkins at Julia.tomkins@asco.org or 571-483-1651 with any questions or requests for additional information.

Sincerely,



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