



The Society for Cardiovascular Angiography and Interventions Foundation

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September 2, 2014

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Marilyn B. Tavenner, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1612-P
P.O. Box 8013
Baltimore, MD 21244-8013

**Submitted electronically via <http://www.regulations.gov>,
<http://www.regulations.gov/#!documentDetail;D=CMS-2014-0094-0002>**

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 [CMS-1612-P]

Dear Ms. Tavenner:

The Society for Cardiovascular Angiography and Interventions (SCAI) is a non-profit professional association with over 4,000 members representing the majority of practicing interventional cardiologists in the United States. SCAI promotes excellence in invasive and interventional cardiovascular medicine through physician education and representation, and the advancement of quality standards to enhance patient care. SCAI having reviewed the “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 [CMS-1612-P]” offers the following comments:

Summary

While not subject to the rule-making process, first and foremost, SCAI would like to thank and commend CMS staff for their support of SCAI’s request and the diligence they exhibited in establishing the new “C3” specialty code for interventional cardiology that is scheduled to become effective on January 1, 2015 as publically announced in the August 22, 2014 Medlearn article <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8812.pdf>.

There appears to be a refreshing new willingness to make changes in the status quo amongst CMS staff focused on trying to continually improve and enhance the existing Medicare program. SCAI found the 2015 Medicare Physician Fee Schedule (MPFS) proposed rule to include several thought provoking proposals

by CMS staff that appear to be truly aimed at enhancement and improvement of the MPFS, balancing both the interest of Medicare beneficiaries and the providers that serve them.

For example, CMS's willingness to consider altering the current process in support of enhancing transparency in rate setting is gratefully appreciated with the only criticism we have regarding this proposal being the very aggressive timeline being proposed by CMS. We support the slightly delayed implementation schedule being proposed by the American Medical Association as we do not believe those meeting past submission deadlines for new code creation proposals should see a delay in the implementation of their anticipated new codes as a result of this proposed change to the process.

We're also intrigued by the proposal to eliminate 10-day and 90-day global periods. If properly executed, SCAI strongly believes that greater accuracy in the valuation of services could possibly be achieved through the elimination of these global periods. However, we are concerned that a rush to implement could interject values that are equally inaccurate. SCAI strongly urges CMS to work through the RUC process to address the elimination of global periods to address concerns regarding potentially misvalued 10- and 90-day global period codes. We do not support the replacement of existing values with values that are merely estimated, which could prove to potentially be just as inaccurate or even more inaccurate.

We again must commend CMS staff this time regarding their work associated with the mandated review of malpractice relative value units (MP-RVUs). On several occasions in the past, SCAI has had to pursue retroactive correction to the MP-RVUs for interventional cardiology services that were inadvertently assigned the non-surgical cardiology malpractice factor instead of the appropriate assignment of the surgical cardiology factor. CMS appears to have correctly identified the vast bulk of 90000 series interventional cardiology codes that should be subject to the cardiology surgical malpractice factor; only overlooking just a few codes in this series - 92961, 92986, 92987, 92990, 92992, 92993, 92997, 92998. With correction of applying the cardiology surgical factor to these codes, a cumbersome, retroactive correction will be averted. Our specific request regarding these codes is described below.

SCAI serves as the primary voice for interventional cardiologists, who will be recognized as a unique specialty under the Medicare program effective January 1, 2014. We look forward to working with CMS to address issues of high interest to the interventional cardiology community. We appreciate CMS consideration of our more detailed and thoughtful comments that follow.

Specific Comments

Sustainable Growth Rate (SGR) Impact on Conversion Factor

The proposed rule does not address the conversion factor calculation, as the PAMA (Protecting Access to Medicare Act) of 2014 effectively froze the conversion factor through the 1st quarter of 2015. CMS asserts that they support "legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care." We concur and support CMS in urging Congress to find a permanent solution to the SGR issue.

Misvalued Codes

CMS continues to engage in efforts to target potentially misvalued codes on an ongoing, "rolling" bases. As CMS knows, the AMA RBRVS Update Committee (RUC) acts swiftly to address all

services identified by CMS as being potentially misvalued. SCAI will be engaged through the RUC process in addressing the valuation of several peripheral cardiovascular codes of interest to our members including support for the development of practice expense inputs for the peripheral IVUS codes (37250/37251) supporting the creation of a non-facility rate for these services.

SCAI is committed to continued engagement through the RUC process in addressing codes identified by CMS as having potentially misvalued services.

Global Surgery

Affording potential significant impact is a proposal by CMS, under the misvalued code initiative, to transform all 10- and 90-day global codes to 0-day global codes beginning in CY 2017. CMS reports, “The Office of the Inspector General has identified a number of surgical procedures that include more visits in the global period than are being furnished”. The RUC has formed a work group around this issue with which SCAI is engaged.

SCAI is intrigued by the proposal to eliminate 10-day and 90-day global periods. If properly executed, SCAI strongly believes that greater accuracy in the valuation of services could possibly be achieved through the elimination of these global periods. However, we are concerned that a rush to implement this policy could interject values that are equally inaccurate. SCAI strongly urges CMS to work through the RUC process to address the elimination of global periods to address concerns regarding potentially misvalued 10- and 90-day global period codes. We do not support the replacement of existing values with values that are merely estimated, which could prove to potentially be just as inaccurate or even more inaccurate.

SCAI recommends CMS work with the RUC in addressing the proposed elimination of 10- and 90-day global periods.

Enhanced Transparency in Rate-setting

CMS has proposed to “enhance transparency in PFS rate-setting”, which translates into altering and effectively, temporarily extending the timeline for the implementation of the values for revalued and new codes. Overall, SCAI supports this proposal, which would afford greater public input into CMS rate setting for procedures. Our only criticism of this proposal is the aggressive timeline being proposed by CMS. We support the slightly delayed implementation schedule being proposed by the American Medical Association as we do not believe those meeting past submission deadlines for new code creation proposals should see a delay in the implementation of their anticipated new codes as a result of this proposed change to the process.

SCAI recommends CMS adopt the proposed new time line for the valuation of new and existing codes being asserted by the AMA, so as to not disenfranchise those new codes that are already in the pipeline for 2016.

Adjustments to Malpractice RVUs

SCAI greatly appreciates the consideration that CMS has extended to invasive and interventional cardiologists by classifying invasive cardiology procedures as “surgery” for the purposes of calculating malpractice relative value units (MP RVUs) (F.R. page 40353). It is well established that

interventional cardiologists pay higher malpractice premiums than general cardiologists. On several occasions in the past, SCAI has had to pursue retroactive correction to the MP-RVUs for interventional cardiology services that were inadvertently assigned the non-surgical cardiology malpractice factor instead of the appropriate assignment of the surgical cardiology factor. CMS appears to have correctly identified the vast bulk of 90000 series interventional cardiology codes that should be subject to the cardiology surgical malpractice factor; only overlooking just a few codes in this series - 92961, 92986, 92987, 92990, 92992, 92993, 92997, 92998. With correction of applying the cardiology surgical factor to these codes, a cumbersome, retroactive correction will be averted.

However, we remain puzzled by the fact that the professional and global portions of the MP-RVUs of the diagnostic cardiac catheterization codes (CPT codes 93451–93461) on this list (Table 15) decline by 6 to 12%. Meanwhile the rarely billed technical component portions (billed about 5% of the time) of these codes rise by 20 to 33%. We recognize that the split between professional components and technical components does complicate the calculation of MP-RVUs for these codes, but that same complication exists in the 2014 valuations. We also recognize that these codes have been classified as surgery for the purposes MP-RVU calculations for many years. We don't understand the reasons for this large shift of MP-RVUs from global and technical component codes toward the rarely used technical component codes. We encourage CMS to review the reason(s) for these changes and to make corrections if appropriate.

SCAI supports the application of the surgical cardiology malpractice factor to interventional cardiology codes as identified by CMS. We ask CMS to correct and expand this listing to additionally include the interventional cardiology procedures described by codes 92961, 92986, 92987, 92990, 92992, 92993, 92997, 92998. Additionally, we ask CMS to reexamine the MP-RVU rates for the diagnostic cardiac catheterization codes (93451-93461), which appear to be anomalous.

Off-Campus Provider-Based Departments

CMS has proposed to begin collecting data on services furnished in off-campus provider-based departments beginning in 2015 by requiring hospitals and physicians to report a modifier for those services furnished in an off-campus provider-based department on both hospital and physician claims. As many studies are showing a mass exodus of cardiology practices moving from private practice to hospital employment, SCAI has high interest in these data and issue. However, we have concerns that the approach to collecting these data being proposed by CMS may present a significant claims processing burden to providers and facilities and therefore, we urge CMS to consider alternative approaches to garnering these data.

SCAI recommends CMS look to alternative methods to garner data regarding the services being provided in the off-campus provider-based department setting than that proposed.

Open Payments Program

CMS proposes significant changes to their Open Payments program, which requires the public reporting of financial relationships between drug and device manufacturers and certain health care providers. SCAI lent endorsement to both the July 28, 2015 Alliance of Specialty Medicine sign-on letter (see [Attachment 1](#)) and the August 5, 2014 AMA sign-on letter (see [Attachment 2](#)) sent to CMS addressing issues and concerns pertaining to the Open Payment Program.

SCAI recommends that CMS work with the Alliance of Specialty Medicine and the AMA to address the concerns regarding the Open Payments program.

Conclusion

SCAI appreciates the opportunity to provide comment to CMS on issues of high interest to the interventional cardiology community contained in the “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 [CMS-1612-P]”. If SCAI can be of any assistance as CMS continues to consider and review these issues, please do not hesitate to contact Mrs. Dawn R. Gray (Hopkins), Director of Reimbursement & Regulatory Affairs at (800) 253-4636, ext. 510 or dgray@scai.org.

Sincerely,



Charles E. Chambers, MD, FSCAI
SCAI President, 2014-2015

CC: Gail Addis, CMS
Chava Sheffield, CMS
Kathy Kersell, CMS
Jessica Bruton, CMS
Craig Dobyski, CMS
James Blankenship, MD, FSCAI
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Clifford J. Kavinsky, MD, PhD, FSCAI
Kathy David, SCAI
Wayne Powell, SCAI
Joel Harder, SCAI
Dawn R. Gray (Hopkins), SCAI



Sound Policy. Quality Care.

July 28, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-0813

Re: Open Payments Program: Registration Processes / Review, Dispute and Correction of Public Data

Dear Administrator Tavenner:

On behalf of the Alliance of Specialty Medicine (the Alliance) and its member organizations, we write to share concerns with the implementation of the Open Payments program. The Alliance is a coalition of medical specialty societies representing more than 100,000 physicians and surgeons dedicated to the development of sound federal healthcare policy that fosters patient access to the highest quality specialty care. Our members are concerned about difficulties accessing and completing registration for Open Payments in a timely manner and believe that the program's structure lacks adequate means to limit publication of inaccurate information, which harms both patients and providers.

Throughout the Open Payments rulemaking process, our societies have supported the underlying goal of transparency, while also believing that relationships between physicians and the health care industry can lead to important advancements in technology and improved patient care. We have also been receptive to efforts to develop uniform procedures for disclosing relevant information in a way that minimizes confusion and misrepresentation. However, we ask that the Centers for Medicare and Medicaid Services (CMS) address the following concerns prior to publication of any financial data.

Difficult Registration Process Needs Sufficient Clarity and Enhanced Guidance

The Alliance appreciates the time constraints and daunting logistical concerns that CMS faced while implementing Open Payments. In that regard, the specialty medicine community applauds the ongoing flow of information facilitated by officials at CMS, which continues to be of great value to the provider community. However, we are concerned that the lack of adequate notice before the beginning of registration periods has handicapped providers that hope to participate in the program in

American Academy of Facial Plastic and Reconstructive Surgery • American Association of Neurological Surgeons
American College of Mohs Surgery • American Gastroenterological Association
American Society of Cataract & Refractive Surgery • American Society of Echocardiography • American Society of Plastic Surgeons
American Urological Association • Coalition of State Rheumatology Organizations • Congress of Neurological Surgeons
North American Spine Society • Society for Cardiovascular Angiography and Interventions • Society for Excellence in Eyecare

a meaningful manner. This concern is magnified by the lengthy registration process and the obstacles it poses.

Given the importance of sufficient participation levels and the role of physicians in ensuring data integrity, the Alliance is concerned that the failure to provide sufficient notice could be a detriment to the program's performance. Further, members of the provider community have legitimate worries about the lack of guidance and the complexity of enrollment mechanisms. We respectfully ask that CMS provide additional provider-specific guidance for the registration process and adopt policies that allow for flexibility of enrollment requirements so that physicians struggling to enroll remain able to participate prior to data publication.

Review and Dispute Process Lacks Necessary Protections for Physicians

The Alliance in previous comments to CMS spoke to the importance of an impartial process for disputing the accuracy of financial information intended for public disclosure. On February 17, 2012, the Alliance specifically asked that CMS assume responsibility for ensuring the validity of published data as a means of both enhancing the integrity of the information and lessening burdens on providers in the absence of a uniform dispute process. Unfortunately, CMS recently made clear that the burden of disputes and adjudication falls entirely on health care providers and industry.

Our members are concerned that this approach does not provide a sufficient means of challenging false information or miscalculations, which can have a significant impact on a physician's credibility and practice. This is particularly troublesome for disputes involving data that depends on allocation of larger costs or requires combining many smaller transactions throughout the year, such as food and beverage totals. In these situations, correction of the misinformation will rely completely on the ability of industry reporting entities to execute the appeal in a timely manner. Already anecdotal evidence is demonstrating that reporting entities are sometimes unable to respond quickly, which has a disproportionate impact on physicians and leaves no alternative appeals mechanism.

In the absence of a well-defined reconciliation process, the Alliance believes that CMS should safeguard the mission of the Open Payments program by taking steps to limit the publication of false information that can impact patient decision-making. However, CMS in its guidance to health care providers stated that information under dispute without reconciliation will nonetheless be posted online for public viewing with a disclaimer. The Alliance believes that the disclaimer offered by CMS fails to sufficiently protect the reputation of health care providers and distributes actionable, but potentially false, information that could impact a patient's decision to choose a health care provider.

As the collector and publisher of financial information, we respectfully ask that CMS take steps to enhance the fairness and accuracy of the Open Payments program by ensuring that health care providers have access to a meaningful mechanism for limiting the distribution of disputed information. Current standards fail to meet these goals by creating a reporting system where the default result of any dispute is publication, whether with or without a disclaimer. Such a process fails to fully consider the significant weight that patients may place on the information published by CMS and the prejudicial effect that even disputed information can have on health care decision-making.

For these reasons, we strongly support revisions to the Open Payments program to ensure that health care providers have access to a fair and impartial means of disputing inaccurate information and protecting against its publication. Thank you for your consideration of the concerns of specialty physicians.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society for Cardiovascular Angiography and Interventions
Society for Excellence in Eyecare

August 5, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Tavenner:

The undersigned medical associations and medical specialty societies are writing to register serious concerns with implementation of the Physician Payments Sunshine Act (Sunshine Act) and to request an expanded timeframe to allow recipients to register, review, and dispute their data in the Open Payments System before publication. Our organizations represent physicians who are directly impacted as covered recipients in the Open Payments System or indirectly impacted through their affiliation with teaching hospitals. Many of our organizations supported passage of the Sunshine Act and, fundamentally, we have no issue with efforts to increase transparency in the interactions between physicians and industry. However, we have a number of serious concerns regarding how the Open Payments System has been implemented.

Significant Expansion of Reporting Requirement – Educational Activities

In the proposed Medicare Physician Fee Schedule for 2015, the Centers for Medicare and Medicaid Services (CMS) has proposed revoking the existing Sunshine Act reporting exclusion for continuing medical education (CME) activities, due in large part to requests from other accrediting bodies that they be added to the list of exempt organizations covered by the exclusion. Instead, the proposal would exempt third party transfers to Continuing Education (CE) only where an industry donor is unaware of the recipients/beneficiaries before and after the funds are transferred. Our organizations believe that this raises concerns as industry could learn the identities of speakers/faculty and potentially participants after the funds have been transferred through brochures, programs, and other publications, or through their physician-employees' participation in CE activities (either as speakers/faculty or attendees). Our organizations are concerned that this would have a significant, chilling impact on CE, which runs contrary to the public interest. **We therefore recommend strongly that the CMS 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.**

In addition, when it passed the Sunshine Act Congress outlined 12 specific exclusions from the reporting requirement, including “[e]ducational materials that directly benefit patients or are intended for patient use.” In an overbroad interpretation of the statute, CMS concluded that medical textbooks, reprints of peer reviewed scientific clinical journal articles, and other services used to educate physicians were not covered by this exclusion even though these clearly have a direct benefit to patients and their medical care.

The importance of up-to-date, peer reviewed scientific medical information as the foundation for good medical care is well documented. Independent, peer reviewed medical textbooks and journal article supplements and reprints represent the gold standard in evidence-based medical knowledge and provide a direct benefit to patients because better informed clinicians render better care to their patients. The Agency's decision to not cover these materials under the educational materials exclusion is inconsistent with the statutory language on its face, congressional intent, and the reality of clinical practice where patients benefit directly from improved physician medical knowledge. **Our organizations urge the Agency 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 Registration Impeded by Condensed Timeframe

There are widespread concerns that the implementation of this new system for data collection—without minimally a six month period to upload the data, process registrations, generate aggregated individualized reports, and manage the dispute communications and updates—will not be ready and will likely lead to the release of inaccurate, misleading, and false information. The Agency has not provided effective notification to the vast majority of physicians nor provided a reasonable amount of time for the undersigned organizations to engage and educate physicians on the registration and dispute process. Early in the regulatory process, medicine informed CMS that a minimum of six months would be needed to ensure an adequate amount of time for outreach on registration and the dispute process. As soon as our organizations learned the date that physicians could begin registering for each phase, a concerted communications campaign was launched. The content had to be developed after the abbreviated period for registration began and with limited opportunity to develop materials because of the compressed period for registration and dispute in advance of publication. Thus, we know that it is extremely likely that many physicians impacted by the Sunshine Act reporting are not aware of the registration requirement and based on feedback thus far certainly will not have adequate time to register prior to the deadline for flagging inaccurate data in the public database. Accordingly, **our organizations strongly urge CMS and the Office of Management and Budget (OMB) to postpone for six months, until March 31, 2015, the publication of the information collected in the Open Payments System, to compensate for this year's six months delay in providing the opportunity for physicians to register, contrary to Agency communications throughout 2013 representing that physicians would be permitted to do so beginning January 1.**

Complicated and Incomplete Guidance Exacerbates Condensed Registration Timeframe

Perhaps most troubling, many physicians are expressing frustration at an overly complex registration process which, combined with the condensed timeframe, makes the task of reviewing and disputing reports by August 27 effectively impossible for the Agency's estimated 224,000 covered physician recipients. We have previously stated that CMS' number is likely an extremely low estimate of impacted physicians. CMS has suggested that it will take 30-45 minutes to complete the 5-step process of registering in the Open Payments system. Our own analysis suggests a substantially more complex 11-step registration process, which does not include the pre-registration step of verifying identity in Medicare's Enterprise Identity Management (EIDM) System. Moreover, when the post-registration time it takes to review and dispute data is factored in, there are an additional 5 steps layered on top of the already cumbersome registration process. This process must be streamlined and physicians must be given adequate time to review and dispute their reports. Thus, **we repeat our request that CMS and OMB delay for six months the publication of the information collected in the Open Payments System until March 31, 2015.**

Moreover, our organizations have serious concerns that Agency guidance gives manufacturers the power to unilaterally dismiss disputes that were initiated by physicians or teaching hospitals. These concerns are the result of language that was buried in the supplementary documents of a May 5th Federal Register Notice, stating that manufacturers “after reviewing the disputed information, if they determine that no change is required to the data, may dismiss the dispute or request that physician or teaching hospital who initiated the dispute to withdraw it.” The February 2013 Final Rule does not authorize manufacturers or group purchasing organizations (GPOs) to dismiss disputes without both parties agreeing that the dispute is resolved. If no resolution is reached, the manufacturer’s or GPO’s reported data will be flagged as disputed in the public database until resolution has been reached between the parties. In a June 24th meeting with AMA and specialty society staff, CMS officials stated their intent to issue clarifying guidance that manufacturers and GPOs are not authorized by the agency to unilaterally dismiss disputes. While Agency officials have indicated that they have clarified the guidance to manufacturers, requests from our organizations to see the written changes have gone unanswered. **We request that the Agency provide the clarifying guidance to physicians/teaching hospitals, to manufacturers/GPOs, and to our organizations.**

Sincerely,

American Medical Association
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma and Immunology
American Academy of Child & Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Disability Evaluating Physicians
American Academy of Emergency Medicine
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Association for Geriatric Psychiatry
American Association of Clinical Endocrinologists
American Association of Neuromuscular and Electrodiagnostic Medicine
American Association of Orthopaedic Surgeons
American Clinical Neurophysiology Society
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Medical Genetics
American College of Occupational and Environmental Medicine
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Phlebology
American College of Radiology
American College of Rheumatology
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Psychiatric Association
American Society for Aesthetic Plastic Surgery
American Society for Clinical Pathology

American Society for Dermatologic Surgery Association
American Society for Radiation Oncology
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Bariatric Physicians
American Society of Cataract & Refractive Surgery
American Society of Dermatopathology
American Society of Hematology
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Transplant Surgeons
American Thoracic Society
American Urological Association
American Women's Association
American Society of Echocardiography
College of American Pathologists
Digestive Health Physicians Association
Infectious Diseases Society of America
Large Urology Group Practice Association
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Critical Care Medicine
Society of Hospital Medicine
Society of Interventional Radiology
Society of Thoracic Surgeons
The Endocrine Society

Medical Association of the State of Alabama
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association, Inc.
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society

Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wyoming Medical Society