1949 - 2009
AMERICAN COLLEGE
OF CARDIOLOGY
Helping Cardiovascular Professionals
Learn. Advance. Heal.

Heart House
2400 N Street, NW
Washington, DC 20037-1153
USA

202.375.6000
800.253.4636
Fax: 202.375.7000
www.acc.org

President
Alfred A. Bove, M.D., Ph.D., F.A.C.C.

President-Elect
Ralph G. Brindis, M.D., M.P.H., F.A.C.C.

Immediate Past President
W. Douglas Weaver, M.D., M.A.C.C.

Vice President
David R. Holmes, Jr., M.D., F.A.C.C.

Secretary
John G. Harold, M.D., F.A.C.C.

Treasurer
Richard A. Chazal, M.D., F.A.C.C.

Chair, Board of Governors
John G. Harold, M.D., F.A.C.C.

Trustees
Elliott M. Antman, M.D., F.A.C.C.
Eric R. Bates, M.D., F.A.C.C.
Alfred A. Bove, M.D., Ph.D., F.A.C.C.
Ralph G. Brindis, M.D., M.P.H., F.A.C.C.
A. John Camm, M.D., F.A.C.C.
Richard A. Chazal, M.D., F.A.C.C.
Gregory J. Dehmer, M.D., F.A.C.C.
Paul L. Douglass, M.D., F.A.C.C.
James T. Dove, M.D., M.A.C.C.
Robert A. Guyton, M.D., F.A.C.C.
John G. Harold, M.D., F.A.C.C.*
Robert A. Harrington, M.D., F.A.C.C.
David R. Holmes, Jr., M.D., F.A.C.C.
Jerry D. Kennett, M.D., F.A.C.C.
Richard J. Kovacs, M.D., F.A.C.C.*
Gerard R. Martin, M.D., F.A.C.C.
Charles R. McKay, M.D., F.A.C.C.
Rick A. Nishimura, M.D., F.A.C.C.
Steven E. Nissen, M.D., M.A.C.C.
Patrick T. O'Gara, M.D., F.A.C.C.
George P. Rodgers, M.D., F.A.C.C.
John S. Rumsfeld, M.D., Ph.D., F.A.C.C.
Jane E. Schauer, M.D., Ph.D., F.A.C.C.*
James E. Udelson, M.D., F.A.C.C.
C. Michael Valentine, M.D., F.A.C.C.
Mary Norine Walsh, M.D., F.A.C.C.
Carol A. Warnes, M.D., F.A.C.C.
W. Douglas Weaver, M.D., M.A.C.C.
Kim Allan Williams, M.D., F.A.C.C.
Stuart A. Winston, D.O., F.A.C.C.

**ex officio*

Chief Executive Officer
John C. Lewin, M.D.

December 28, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8011
Baltimore, MD 21244-8018

ATTENTION: **CMS-1413-FC**

Dear Ms. Frizzera:

The American College of Cardiology (ACC) is pleased to offer our comments on the final rule with comment period entitled **Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010** as published in the Federal Register on November 25, 2009.

The ACC is a professional medical society and teaching institution made up of 37,000 cardiovascular professionals from around the world – including 90 percent of practicing cardiologists in the United States and a growing number of registered nurses, clinical nurse specialists, nurse practitioners, physician assistants, and clinical pharmacists. Our goal in commenting on these policy changes is to assure access to quality cardiovascular care for all Americans.

The policies contained in this final rule are already causing an abrupt shift in the practice of cardiovascular medicine in the United States as physicians are, as a result of this rule, leaving the private practice of cardiology in droves. Many patients who now receive outpatient cardiovascular care in their physicians' office will be forced to seek those services in the hospital setting or from offices in the community linked to particular hospitals, leading to increased costs and access issues. The ACC remains committed to working with CMS to provide access to quality cardiovascular care but we are concerned that the impact of this rule will cause permanent, irreversible damage to community-based cardiology care.

Practice Expense
In this final rule, CMS finalizes its decision to generate practice expense relative value units (RVUs) based on a new Physician Practice Information Survey (PPIS) that was completed by the American Medical Association (AMA). As we stated in our attached comment letter on the proposed rule, we do not believe these data may be properly used as the basis for setting the practice expense reimbursement amount.. While CMS proposed to slow the impact by phasing in the impact over four years, the phase in provides only a modest, short term relief from the rule's major, negative impact on the fiscal health of cardiology practices.

Many of the concerns that we raised in our comments on the proposed rule have not yet been addressed despite numerous meetings with CMS staff and leadership. The most significant additional analysis that CMS provided as part of the final rule was an analysis of differences between the supplemental survey data and PPIS data for the specialties of cardiology, radiology, and urology performed by the Lewin Group. The analysis is mentioned within the CMS rule and the only statement from CMS is that the Lewin Group's analysis did not change CMS's decision to finalize the proposal based on this information.

First, this is the kind of analysis that CMS should have performed on all specialties and should have included in the proposed rule. Releasing a partial analysis of the data at the time that the rule is finalized does not allow time for stakeholders to comment on the decisions that were made prior to implementation. We reviewed the Lewin Report with great interest, focusing on the review of the cardiology data. The Lewin Group analysis validated that the supplemental survey was far more reflective of the costs of cardiology practice than the data gathered as part of the PPIS. Indeed, the Lewin Group states that costs of practice have not gone down since the supplemental survey and that there was even more rapid shifting towards office-based cardiology services since that time. The Lewin Group states that the two surveys are measuring two different groups of cardiologists and that the supplemental survey is more representative of cardiologists than is the PPIS. The ACC concurs with that assessment and believes that CMS should not use the PPIS data when the Lewin Group's analysis indicates that the supplemental survey data is more representative and precise than the PPIS data

Many of the cardiologists who responded to the PPIS appear to be from hospital-based practices or otherwise integrated systems that do not bear the indirect costs associated with technical component services. However, the data used in the PPIS has the largest impact on services with significant technical components, cutting payments to nuclear cardiology services and echocardiography by more than 20 percent. The PPIS data do not reflect typical practice expenses for practices that provide the services most affected by implementation of the data. CMS provided no response to the point that there are two very distinct kinds of cardiology practices, not considering whether one or the other might be more representative of the costs that CMS intends to cover through the physician fee schedule.

The numerous defects in the PPIS, and the clear superiority of the supplemental survey,

are further corroborated by the analysis of Henry Miller, Ph.D., a recognized national expert on the subject of surveys of physician practice expenses retained by the ACC as a consultant to review PPIS. A copy of Dr. Miller's analysis is attached hereto. Dr. Miller's conclusions include the following:

1) The PPIS response rate for cardiology practices falls well below CMS's own requirements for survey response rates, as well as industry standards,
2)Based on available evidence, the 55 survey responses used to measure cardiology practice expenses are not representative of the distribution of U.S. cardiology practices,
3)The questions relating to practice expenses included in the PPIS do not meet the requirements of generally accepted cost accounting principles and were not constructed to ensure consistent responses, and
4)The difference between practice expenses measured in the currently used Supplemental Survey for cardiology and practice expenses measured in the PPIS is so great that CMS should not change from using the SS to the PPIS for cardiology.

The ACC strongly urges CMS to take the additional time available before the rulemaking cycle for the 2011 Medicare Physician Fee Schedule to consider whether the data and methodology fully take into account the costs of providing services to Medicare beneficiaries in community based settings. Based on all available information we do not believe CMS is using accurate practice expense information.

As CMS notes in this final rule, the Medicare Payment Advisory Commission (MedPAC) has stated its concerns that the use of a survey and the artificial application of that data may not allow for the most accurate practice expense values. The ACC remains concerned that the PPIS methodology fails to capture practice expenses accurately and reliably. As shown in Table 2 of the Final Rule, there is wide variation in practice expense per hour among specialties, even those specialties that would likely have very similar practice operations and levels of overhead.

In addition to concerns about the PPIS data, the ACC has broader concerns about the resource-based practice expense methodology. One critical issue that remains difficult to understand is the scaling factor that is applied to direct inputs as the first step in determining a practice expense RVU. We are uncertain why a global scaling factor should be applied in this fashion. More importantly, we question how the number could change so significantly over time The PPIS shows that 74% of physician practice expense are related to indirect costs, an increase of more than 10% compared to the current data. This results in a change of the scaling factor that reduces the payment for direct practice expense inputs from 0.62 to 0.51. As more and more services that had been restricted to facility settings move into an office environment, direct physician costs have gone up substantially. While the administrative burdens that may be captured in indirect costs have increased for physicians in that same time, it does not seem plausible that the split between direct and indirect costs could move upwards so substantially in that time.

While the ACC understands that appropriate assignment of indirect costs for defined services is complex and challenging and that CMS's indirect cost formula has developed

over many years, this year's rule revealed some significant flaws in the methodology that CMS must address in the 2011 proposed rule. The ACC hopes to meet with CMS staff in the near future to discuss these concerns and hopes that CMS is open to further refinements of this system.

Malpractice RVUs

CMS finalized a modified version of the proposals to incorporate new malpractice premium data into the malpractice RVUs (MP RVUs) and introduce a new resource based MP RVU methodology for technical component services. The ACC is disappointed that CMS chose to implement the new data and new methodology for technical component services without a multi-year phase-in as recommended in our comments on the proposed rule. Although the MP RVUs account for a small share of aggregate payments under the Medicare Physician Fee Schedule, the reduction in RVUs for technical component services is significant. In addition, the new resource based methodology is being implemented in conjunction with other RVUs changes that adversely affect many technical component services.

The ACC supports the modifications CMS has made to its proposal with respect to technical component services. Specifically, we agree that the verified malpractice premium data for IDTFs should be used instead of the medical physicists' premium data cited in the proposed rule. We also support the modification of the resource based PE methodology for technical component services to use the greater of the clinical labor required for a service or the work RVUs in the malpractice allocation.

The ACC comments on the proposed rule expressed concern about CMS's proposal to assign services to one of three risk tiers – non-surgical, minor surgical, and major surgical – solely on the basis of CPT code range and global surgical indicator. We agree with CMS's decision not to finalize this aspect of the proposal and to, instead, use the current approach for assigning risk factors to individual services. We look forward to working with CMS to address unresolved issues in the assignment of risk factors to individual services, including the appropriate risk factor assignment for injection procedures performed in conjunction with cardiac catheterization.

We have specific concerns with respect to the 2010 MP RVUs assigned to a number of electrophysiology, diagnostic cardiac catheterization, and interventional cardiology procedures. The Final Rule indicates that in addition to services in the CPT code range 10000 through 69999, the following codes would continue to be assigned the surgical risk factor:

92980 through 92998, 92973 through 92975 (percutaneous coronary interventions)
93501 through 93536 (diagnostic cardiac catheterization)
93580 through 93581 (repair of congenital heart defects)
93600 – 93613, 93617 – 93641 (electrophysiology studies and ablation procedures).

CMS's decision to maintain the surgical risk factor for these services is appropriate. We believe, however, that CMS has made an error and has not, in fact, assigned the cardiology surgical risk factor to the services listed above. In all instances, the 2010 MP

RVUs for these services are lower than both the 2009 MP RVUs and the proposed 2010 MP RVUs published in the proposed rule. These decreases are unexplained and inconsistent with the results we would expect to see from the policy as stated in the Final Rule. The ACC strongly urges CMS to re-examine the risk factor assignments for these codes, recalculate the MP RVUs as needed, and promptly issue a technical correction if, as we suspect, the published MP RVUs are incorrect.

Consultations

The ACC continues to disagree strongly with the CMS decision to eliminate payment for services reported as consultations. As we stated in our comments on the proposed rule, a consultation is not merely an office or hospital visit with the addition of a report sent to the requesting physician. We restate our strong opposition to elimination of payment for the consultation codes and urge that CMS wait at least a year before implementing such a change because of the enormously disruptive administrative problems this policy will create.

Since this change was finalized on November 1, ACC members have raised significant questions about how to report services that are now reported as consultations. With only weeks to go before the change, specialty societies like ACC were unable to educate members on how to report services they report on a daily basis. In the rule, CMS appears to ignore and dismiss the concerns raised by the many stakeholders that opposed this change. While we will do everything possible to make this transition easy for our members, these issues are likely to cause lost or delayed revenues for physicians who are providing valuable services for Medicare beneficiaries.

Potentially Misvalued Services

The ACC shares the CMS goal of establishing appropriate payment for services provided to Medicare beneficiaries. However, the ACC is concerned that expanding the effort to examine services that are commonly performed together to a threshold of 75% will and not result in substantial savings of funds on these services and will instead result only in more work for specialty societies, CMS and the RUC, as well as a more cumbersome and confusing coding system.

CMS should continue to explore appropriate ways to pay for services in a more systematic fashion. If CMS wishes to continue to pursue actions that create new codes to replace old codes, the values for those new codes should be subject to the same rulemaking requirements as changes to existing codes. Such changes should be published in the proposed rule to allow the public to comment. In addition, should policy changes with a significant impact on existing services coincide or overall with the introduction of codes created through the potentially misvalued codes activities, the new codes should be subject to any transition or phase-in. We are aware that multiple proposals to bundle codes commonly reported together are moving through the CPT and RUC processes, with implementation scheduled for January 2011. We urge CMS to propose RVUs for those new, bundled codes in the proposed rule for the 2011.

Physician Quality Reporting Initiative

While the ACC is concerned that some physicians will be unable to participate in PQRI in 2010 due to reduced options for claims based reporting, we salutes CMS for its commitment to transform the program from a claims-based system into one requiring the use of a registry or an electronic medical record. We hope that the program will continue to evolve into one that pays a meaningful bonus for meaningful work contributing to quality care provided to Medicare patients.

The addition of measures groups for coronary artery disease and heart failure should allow more cardiologists to submit measure on a like group of patients and allow them to better determine where to focus their quality improvement resources.

E-Prescribing

As stated in our comments on the proposed rule, the ACC supports the CMS decision to change the reporting requirements to receive the e-prescribing bonus. Recognizing that physicians who invest in e-prescribing are likely to continue to do so throughout the year is sensible and requiring the reporting of 25 incidents of e-prescribing is a reasonable requirement to report this.

Refinement of Relative Value Units for Calendar Year 2010 and Response to Public Comments on Interim Relative Value Units for 2009

The ACC appreciates the decision of CMS to accept the recommendation of the refinement panel and increase the work values for a number of cardiac device monitoring services (CPT codes 93283, 93289, 93295). These services were inappropriately devalued as part of the 2009 interim final rule and the ACC appreciates CMS addressing this issue and more accurately aligning the values for the service with the level of work required and the value to the patients.

Establishment of Interim Work Relative Value Units for New and Revised Codes

The ACC strongly objects to the way that CMS has handled the issue of code changes to existing services. According to direction from CMS, the ACC cooperatively worked with CMS to create new codes to allow the report myocardial perfusion imaging services, typically reported with three codes, with a single code. In addition, the ACC, in collaboration with other medical specialty societies, submitted recommendations to the RUC for both reduced practice expense inputs and reduced work values from that which were assigned to the services in 2009.

The ACC has recommended CMS on numerous occasions to recommend that existing services that have changes in codes should be included as part of the proposed rule. The impact of changes in the values of existing services that have been assigned new CPT codes can be significant and should be subject to the provisions of the Administrative Procedures Act requiring a notice of proposed rule making and a comment period. For example, the new CPT code 78452 represents a set of services provided to Medicare beneficiaries 3 million times in 2007. The interim RVUs for 2010 represent a 36% decrease from the RVUs assigned to the previous codes for the service. In the rule, CMS states that it may waive the requirement for a notice of proposed rulemaking if doing so

is impracticable, unnecessary, or contrary to the public interest. CMS states that it believes that it may waive this requirement in the case of new codes because codes are not released until the fall. While the code numbers are not released, this does not appear to be particularly relevant. The description of the codes and an assessment of the work values have already been completed well in advance of the assignment of particular code numbers. In the case of myocardial perfusion imaging, the codes were approved by the AMA CPT Editorial Panel in October of 2008 and values were recommended by the RUC in February of 2009. It is unclear why CMS was unable to discuss these values as part of the proposed rule, which is not released until July.

It is also important that CMS recognize while the RUC allows for the contributions of a number of stakeholders in the medical community, it is not an open meeting and does not meet the transparency requirements of federal advisory committee. In addition, in the case of the myocardial perfusion imaging services, RUC recommendations were rejected in favor of lower work RVUs.

The ACC is further disturbed by the CMS decision to implement changes in "potentially misvalued" codes as part of the interim final rule and not allow for comment prior to implementation. In this section, CMS states that "a delay in implementing revised values for these misvalued codes would perpetuate the known misevaluation of these services". CMS does not know that these services are misvalued, it believes them to be so. While CMS accepted the recommendations of the RUC on most of these services, it does not have to do so, so CMS could arbitrarily cut the value for services by 50 or 60 percent on its own initiative and stakeholders would have no opportunity to comment. The ACC fails to understand how the public could be harmed by deciding not to implement these changes and why such a change should not be subject to notice of proposed rulemaking requirements.

Even more disturbingly, CMS views myocardial perfusion imaging as new services and decided to not phase-in the practice expense relative value unit changes. This once again speaks to a misunderstanding of a new code not necessarily being a new service. The ACC requests that CMS immediately revise its decision and phase-in the practice expense values for myocardial perfusion imaging according to a crosswalk to the codes that exist in 2009.

Not having had the opportunity to comment on these values prior to implementation, ACC has no choice but to do so now. The ACC strongly disagrees with the work values assigned to the myocardial perfusion imaging SPECT codes 78451 and 78452. The ACC performed a survey of physicians who perform these services and after examining the data, made recommendations to the RUC. The ACC continues to believe that those recommendations are correct. The ACC recommends that code 78451 be assigned a work value of 1.5 and that code 78452 be assigned a work value of 1.87.

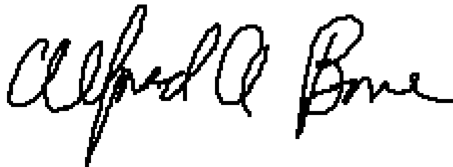
We believe it was inappropriate for CMS to use CPT code 73219 (MR, upper extremity, other than joint, with contrast at RVU 1.62) as a reference code for CPT code 78452. CPT code 73219 has no computer post-processing analysis associated with it, has less

overall images to interpret, and has no additional cine motion images to analyze and interpret, all of which are included in the as MPI procedures. The differential diagnosis, patient complexity/history, and cognitive assessment for good patient outcomes are frequently a different level in the cardiovascular patient.

The ACC urges CMS to correct this work valuation and more importantly to allow stakeholders to comment on these kinds of changes in the future.

The ACC appreciates the opportunity to comment on these very important elements of rulemaking and will be contacting CMS in the near future to discuss further. If you have any questions about this comment letter of wish to discuss further, please contact Brian Whitman, Associate Director of Regulatory Affairs at bwhitman@acc.org or (202) 375-6396.

Sincerely,



Alfred A. Bove, MD, PhD, FACC
President

The mission of the American College of Cardiology is to advocate for quality cardiovascular care — through education, research promotion, development and application of standards and guidelines — and to influence health care policy.