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December 26, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-8018

ATTENTION: **CMS–1403–FC**

Dear Mr. Weems:

The American College of Cardiology (ACC) is pleased to offer our comments on the notice of proposed rulemaking (CMS-1403-P) entitled: "**Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)** as published in the *Federal Register* on November 19, 2008.

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.

IDTF

The ACC appreciates the decision of CMS to not adopt the proposal to require all physician practices that provide diagnostic testing to register as independent diagnostic testing facilities (IDTFs). As ACC stated in comments on the proposed rule, such a proposal would have greatly increased the administrative burden on physician practices without any evidence that it would improve the quality of care for Medicare beneficiaries. The ACC looks forward to working collaboratively with CMS on the implementation of the requirement of the Medicare Improvements for Patients and Providers Act of 2008 that providers of the technical component of advanced diagnostic imaging be accredited. This provision of the law is far more likely to improve the health care of beneficiaries by restricting advanced imaging to those entities that meet the high standard for accreditation. While CMS notes that it may consider finalizing the requirement that physicians register as IDTFs as part of future rulemaking, the ACC does not believe that such an action will be necessary. If CMS believes that such action is necessary, the ACC believes that CMS should propose it as part of a future rule so that interested parties have the opportunity to comment.

Physician and Non-Physician Enrollment Issues
As stated in its comment letter on the proposed rule, the ACC is concerned about the implementation of changes to the requirements of the enrollment process in anticipation of a web-based enrollment process. ACC looks forward to examining the web-based process for enrollment and believes that it will be a significant improvement from the paper-based methodology today, which tends to cause lengthy delays. As of the writing of this letter, CMS has just announced the availability of web-based enrollment in 34 states and has indicated that it will expand this availability throughout the country within the next two months. The ACC urges CMS to continue to monitor trends in enrollment processing time to ensure that physicians and other providers are able to become enrolled as Medicare providers as quickly as possible and to ensure that the web-based enrollment process does not suffer from the safe level of confusion and bureaucratic difficulty of the current system.

Amendment to the Exemption for Computer-Generated Facsimile (Fax)Transmissions From the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard for Transmitting Prescription and Certain Prescription-Related Information for Part D Covered Drugs Prescribed for Part D Eligible Individuals
The ACC appreciates CMS recognizing that the elimination of the fax exemption to electronic prescribing transmission standards would be unlikely to lead to increased utilization of e-prescribing and could instead cause reductions in the use of such systems. The ACC agrees with CMS that the impending bonus payment for the use of a qualified e-prescribing system is far more likely to expand the use of e-prescribing among physicians.

PQRI
The ACC appreciates that CMS will allow registries that successfully report 2008 PQRI data to continue to be considered qualified for 2009. The ACC has invested considerable resources in an outpatient registry known as IC^3 (Improving Continuous Cardiac Care). The ACC hopes that IC^3 will be able to continue as a PQRI-qualified registry.

The ACC notes that CMS has decided to eliminate the claims-based reporting option for a number of measures, including a measure commonly used by cardiologists for the use of beta blocker therapy for patients with prior myocardial infarction (measure #7). CMS will only allow these measures to be reported through a registry, because the claims-based method made it difficult to determine exactly which measure was being reported on. The ACC believes that this points to the value of registries over augmented claims data and hopes that further development of value-based purchasing recognizes this value.

The ACC also notes that the proposed measures group for PQRI reporting for coronary artery disease (CAD) was not finalized by CMS due to difficulty establishing a common denominator for the included quality reporting codes. The ACC urges CMS to develop a new measures group for CAD. Improved management of patients with CAD could offer

tremendous benefit to Medicare beneficiaries. The potential budgetary impact is also significant because cardiac disease is responsible for such a large portion of Medicare spending. The ACC would be happy to work with CMS on identifying the appropriate measures that could potentially compose a group.

Electronic Prescribing Incentive Program

The ACC supported the incentive program for physicians that prescribe electronically that was included in the Medicare Improvements for Patients and Providers Act of 2008 and is pleased to see the implementation of the program for 2009. While the two percent bonus payment authorized by MIPPA for 2009 and 2010 is welcome, we must emphasize that this small bonus which will transition to a penalty in the future is inadequate to support physician efforts to fully implement and realize the benefits of this valuable technology which, properly used, will improve the health of Medicare beneficiaries.

It is unfortunate that physicians have to take an additional administrative step in order to report electronic prescribing, but we understand that the limited time available for CMS to implement this legislative requirement made it difficult to implement in another way. The ACC looks forward to working with CMS to implement a bonus system that recognizes the use of electronic prescribing without requiring this additional administrative step.

As CMS and others look forward to future incentive programs for electronic prescribing, they should consider programs that give an even greater incentive for the use of these systems in an interactive way that takes full advantage of their capabilities. While this first step of payment for acquiring the systems is absolutely necessary, a move towards value-based purchasing will require even more commitment on the part of physicians.

Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2009

ACC appreciates the support of CMS for its new approach to cardiac device monitoring codes. However, it was very concerned to see CMS accept some but not all of the RUC recommendations on the work values for these services. CMS chose not to accept the RUC recommendations for three services: 93283, 93289, and 93295. The ACC, the Heart Rhythm Society, and the RUC spent considerable effort to establish reasonable work RVUs for the new cardiac monitoring codes. We support the RUC's recommendations and strongly urge CMS to accept those recommendations for the following codes.

<u>93283 Programming device evaluation, dual lead ICD</u>

CMS rejected the RUC's recommendation of 1.18 work RVUs, arguing that the increment of work between the single lead (93282) and dual lead service was too high, and instead assigned an interim value of 1.05. ACC disagrees with CMS's assumption that there is a constant increment of work added to the programming evaluation of an ICD as it progresses from a single lead to dual lead device and from a dual lead to

multiple lead device. CMS made this assumption in reducing the value of 93283 from the RUC-recommended 1.18 to 1.05. The ACC requests that CMS accept the work value of 1.18 work RVUs for 93283 as recommended by the RUC.

93289 Interrogation device evaluation, single, dual and multiple lead ICD (in person)
In addition, CMS indicated that it did not accept the RUC-recommended work value of 0.92 for code 93289 and instead proposed to use 0.79. CMS did this because it believed that there should be a linear relationship between the work of ICD and pacemaker programming codes. The ACC does not believe that this is the case as the typical patient for these services may be very different. The ACC is concerned that CMS ignored the work of the RUC in comparing this service to a level 3 office visit (99213) with a work value of 0.92. This 0.92 was even lower than the 1.00 RVUs that represented the 25th percentile on the survey that was completed by physicians that perform the service. Further reducing the work values seems to mean that CMS is questioning the judgment of the physicians that perform this service and instead favors a somewhat arbitrary assignment of work values based on two codes that are less complex. A level 1 hospital visit (99231) and a cardiac stress test (93015) are both less intense services that were not selected as comparison codes by the surveyees. CMS used this new adjusted value for 93289 to reduce the assigned work values for 93295. ACC requests that CMS accept the RUC recommendations of 0.92 work RVUs for 93289 and 1.38 work RVUs for 93295.

In addition, CMS accepted most but not all of the practice expense recommendations for these new codes. CMS notes that it did not accept the recommendations of the RUC on practice inputs for a number of these codes because it did not have an established code for the equipment. CMS instead used established equipment inputs to determine the PE RVU for these services. For codes 93279 through 93292, CMS did not accept the RUC-recommended equipment of a pacemaker monitoring system and instead used an existing input of a pacemaker follow-up system. The ACC believes that a pacemaker follow-up system that is already an established piece of equipment appropriately describes the equipment used for these services and supports the decision of CMS to use them in the PE calculation.

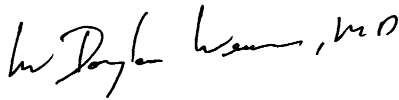
For codes 93293 and 93296, CMS indicates that it did not have an established equipment code for the RUC-recommended input of a pacemaker interrogation system and instead replaced it. The ACC believes that there is a discrepancy in portions of the rule and would ask that CMS clarify what was done. In Table 5 of the rule, CMS notes that it used existing equipment item "pacemaker monitoring system" in place of new equipment described as a "pacemaker interrogation system". However, in the text of the rule on page 69897 of the Federal Register, CMS states that because these two new codes were crosswalked from existing code 93733, CMS has assigned the PE inputs for the pacemaker follow-up system (EQ198). The equipment assigned to code 93733 is in fact that which is described in Table 5, the pacemaker monitoring system. The ACC believes that the equipment that had been described by the RUC as a pacemaker interrogation system is appropriately described by the existing equipment item pacemaker monitoring system. Although this equipment input does not have an equipment item code assigned by CMS, it is priced at $123,250. CMS has also assigned the pacemaker follow up

system (EQ198) to codes 93279-93292. The ACC believes that this substitution is appropriate.

CMS did not completely accept the recommendations of the RUC on new practice expense items for stress echo procedure 93351. CMS requests information on the typical set-up for the number of ultrasound units that are connected to the echocardiography image viewing and reporting system. While there is wide variation in practice based on size and type of practice, the typical practice has two ultrasound units connected to this system.

The ACC appreciates the opportunity to comment on the Medicare physician fee schedule provisions. If you have any questions, please contact Brian Whitman, Associate Director of Regulatory Affairs, at (202) 375-6396 or bwhitman@acc.org.

Sincerely,



W. Douglas Weaver, MD, FACC
President