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*\*ex officio*

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Thomas E. Arend Jr.

August 21, 2006

Submitted Electronically: <http://www.cms.hhs.gov/erulemaking/>

Mark McClellan, MD, PhD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS 1512-PN  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-8018

Dear Dr. McClellan:

The American College of Cardiology (ACC) is a 30,000 member non-profit professional medical society and teaching institution whose mission is to advocate for quality cardiovascular care—through education, research promotion, development and application of standards and guidelines—and to influence health care policy. The College represents more than 90 percent of the cardiologists practicing in the United States.

The ACC is pleased to offer comments on the notice of proposed rulemaking entitled **Medicare Program: Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (CMS 1512-PN)** published in the *Federal Register* on June 29, 2005. Our goal in reviewing proposed Medicare policy changes is to assure access to quality cardiovascular care for Medicare beneficiaries. The College believes that rational, fair physician payment policies are a critical component of adequate access to care. We offer the following comments in support of that goal.

### Practice Expense

The ACC is pleased that CMS modified the informal proposals for revising the practice expense methodology presented at the February 15 Town Hall meeting. In our response to the Town Hall information, the ACC and other cardiovascular organizations expressed grave concerns about the magnitude of the impacts on some specialties, as well as the inadequacy of the methods of allocating indirect practice expenses to codes with no physician work RVUs.

We appreciate that CMS has made some efforts to moderate the effect of the practice expense revisions. Nevertheless, we remain concerned about the impact of large payment decreases for key cardiovascular services at a time when physicians already face increasing economic pressures. Our comments on several aspects of the proposed methodology follow.

#### Supplemental surveys

The ACC is pleased that CMS proposed implementation of the supplemental survey data submitted by seven specialties. We believe that CMS should make use of the best available data in determining the practice expense RVUs. The ACC dedicated considerable staff and physician volunteer time and significant financial resources to submitting supplemental survey data, as provided by the Balanced Budget Refinement Act of 1999 (BBRA) and requested by CMS. Incorporating this data into the CY 2007 fee schedule will increase the accuracy in determining the PE RVUs for the services our members provide, as well as improving the overall accuracy of the practice expense component of the fee schedule.

#### Multi-specialty survey

The American Medical Association (AMA) is sponsoring a multi-specialty supplemental study of practice expense costs. A multi-specialty survey equal in rigor and quality to the supplemental surveys already submitted to and accepted by CMS is a worthwhile endeavor. It is important that the design and structure of the new survey be in compliance with all of the criteria established for the specialty specific practice expense supplemental surveys accepted by CMS. Such a survey will require a significant investment of time and funding. The ACC will continue to work with CMS, the AMA and the physician community to develop plans for updating the practice expense per hour data for all specialties.

#### Transition

The ACC supports CMS's proposal to transition the proposed Practice Expense changes in over a 4-year period. This provides specialty societies and the RUC an opportunity to identify any issues with the current PE data, to make any further appropriate revisions, and to collect additional data as needed prior to the full implementation of the proposed changes.

#### Clinical labor in indirect cost allocation formula

The ACC strongly supports CMS's proposal to use clinical labor costs in the indirect allocation for a service when the clinical labor costs are greater than the physician work RVUs. This proposal represents an important improvement in the indirect cost allocation methodology and is essential to an equitable approach to elimination of the nonphysician work pool. The existing indirect cost allocation formula is wholly inadequate for fairly assigning practice expense relative values to codes with little or no physician work.

### Cardiac catheterization services – non facility

Under CMS's proposed new practice expense methodology, non-facility payment rates for many cardiac catheterization procedures face drastic reductions by 2010. For example, the national average payment for CPT 93510 (Left heart catheterization) would fall from \$1750 in 2006 to \$964 in 2010, not accounting for any changes in the Medicare conversion factor. We note that in the Notice of Proposed Rulemaking released on August 8, CMS proposes carrier pricing for codes in this family when performed in the nonfacility setting. We understand that CMS has proposed this approach for 2007 because of concerns about the accuracy of the direct cost inputs. The ACC will provide more extensive comments about the direct cost inputs for the cardiac catheterization codes in our response to the August rule and will work through the PERC process to ensure the availability of accurate direct cost data for these codes.

We believe also that CMS's data on indirect practice costs may not be appropriate for cardiology practices that operate free standing cardiac catheterization labs. Nonfacility billing of the technical component of cardiac catheterization procedures is dominated by the Independent Diagnostic Testing Facility (IDTF) specialty classification because many non-hospital based cardiac catheterization facilities enroll in Medicare as IDTFs. Thus, the supplemental survey data for IDTFs are influential in determining the IPCI for cardiac catheterization procedures. The IDTF supplemental survey, however, was conducted in free standing imaging centers. Consequently, it may not reflect the costs of cardiology practices that operate outpatient cardiac catheterization labs.

### Cardiac Monitoring Services

Under the proposed new practice expense methodology, payment rates for many cardiac event monitoring services drop dramatically, some even to zero in 2010. For example, the national average payment for CPT 93236 (ECG monitor/report 24 hrs) would fall from \$104.98 in 2006 to \$0 in 2010. We note that in the Notice of Proposed Rulemaking released on August 8, CMS acknowledges the lack of inputs for many of the codes in this family and encourages data submission. The ACC will continue to work CMS and the providers through the PERC process to ensure the availability of accurate direct cost data for these codes.

As with cardiac catheterization services – non facility, ACC believes that CMS's data on IDTF indirect practice costs do not reflect the costs of remote cardiac monitoring. Issues such as hours of operation, intense staffing needs and equipment variances are not taken into account. We encourage CMS to work with the cardiac monitoring provider community to determine accurate indirect cost data.

### **Five Year Review**

#### CPT code 93325 - Doppler Color Flow Add-On

At the September 2005 meeting of the AMA RUC, the RUC could not recommend a change in the value of the code without CPT review of the code. The RUC recommended that code 93325 be referred to the CPT Editorial Panel for consideration for inclusion of the work of 93325 in the

work of 93307. The NPRM, however, stated that (93325 was) referred to the CPT Editorial Panel by the RUC with the recommendation that this service be bundled with CPT code 93307 (Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete). We believe that the NPRM statement mischaracterizes the RUC recommendation in a subtle, but important manner.

The ACC has sent correspondence to both AMA and CMS outlining the rationale for maintaining the current echocardiography nomenclature structure. The current structure allows for the most accurate reporting of the echocardiography procedures that are actually performed by cardiologists and other physicians.

### Cardiothoracic Surgery

The ACC opposes CMS's proposal for revising the work RVUs for cardiothoracic surgical procedures. We urge CMS to instead adopt the RUC's recommendations for these codes for several reasons. First, the RUC developed and approved its recommendations for the cardiothoracic surgical procedures through the process developed for all specialties for the five year review. Although there were some differences between the Society of Thoracic Surgeons' data and methods and the RUC's standard methodology, most of the elements supporting the recommendations – for example, intensity surveys, building block methodology, expert panels – are approaches the RUC has used before to develop either recommendations or the rationale to support a recommendation. Moreover, both the five year review workgroup and the full RUC subjected the STS recommendations and data to a rigorous review and thorough debate before approving the recommendations.

We are concerned that CMS's proposed work RVUs for cardiothoracic surgery threaten to distort relative work intensity both within cardiothoracic code families and across specialties. The RUC recommended intensity for cardiothoracic surgery is on average 2 to 3 times higher than the RUC recommended intensity for office and hospital based non-critical care evaluation and management codes. This relationship is well within historical studies of surgical intensity as it relates to evaluation and management intensity. In addition, the CMS proposal creates rank order anomalies within cardiothoracic surgery. The ACC believes these flaws in the CMS-proposed RVUs will hinder future efforts to assign appropriate work RVUs to cardiothoracic surgery and cardiology procedures.

Finally, the ACC believes that the inappropriately low work RVUs CMS proposes could limit access to important lifesaving care. We are concerned about possible future shortages of qualified cardiothoracic surgeons. Medicare's physician payment system must support the full continuum of treatment options for Medicare beneficiaries with cardiovascular disease. Cardiothoracic surgeons are critical to that continuum of care.

Mark McClellan, MD, PhD  
August 21, 2006  
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Thank you for the opportunity to comment upon this proposed rule. The ACC appreciates CMS' continued willingness to work cooperatively with the physician community to strengthen the Medicare program and improve care for Medicare beneficiaries. Please feel free to contact Rebecca Kelly, ACC's Director of Regulatory Affairs at 301-498-2398 or [rkelly@acc.org](mailto:rkelly@acc.org) with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven Nissen".

Steven E. Nissen, MD, FACC  
American College of Cardiology  
President