



**AMERICAN ACADEMY OF
OTOLARYNGOLOGY—
HEAD AND NECK SURGERY**

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August 31, 2009

Charlene M. Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1413-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

**Re: Medicare Program; Payment Policies under the Physician Fee
Schedule and Other Part B Payment Policies for CY 2010;
Proposed Rule (CMS-1413-P)**

Dear Ms. Frizzera:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the “Payment Policies under the Physician Fee Schedule and Other Part B Payment Policies for CY 2010” published in the Federal Register as a proposed notice on July 13, 2009. Our comments will address the following issues, in the order in which they appear in the proposed rule: (1) resourced-based practice expense relative value units (PE RVUs); (2) malpractice relative value units (RVUs); (3) coding issues, including canalith repositioning, a policy clarification for the use of certain audiology codes and the proposed elimination of consultation codes; (4) potentially misvalued services under the physician fee schedule; and, (5) the proposed conversion factor update for 2010 and the sustainable growth rate (SGR).

Resource Based Practice Expense (PE) Relative Value Units (RVUs)

Significant changes are proposed in the PE RVUs for the vast majority of services paid under the physician fee schedule. These changes are largely due to new data on practice expenses per hour and a revised assumption by CMS regarding the percentage of time expensive equipment is in use during the time an office is open. These issues are described separately below.

Physician Practice Information Survey (PPIS)

The AMA has conducted a new survey, the PPIS, which was expanded (relative to the SMS) to include non-physician practitioners (NPPs) paid under

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the PFS. The PPIS is multispecialty, nationally representative, PE survey of both physician and NPPs using a consistent survey instrument and methods consistent with those used for the SMS and the supplemental surveys. The PPIS gathered information from 3,656 respondents across 51 physician specialty and health care professional groups.

The PPIS, administered in CY 2007 and CY 2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs. The AMA and the CMS contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and non-physician specialties, respectively. For otolaryngology, the PPIS found a total practice expense per hour of \$189.69, representing a 41 percent increase above the previous SMS figure of \$134.64. We believe the new survey data is a better reflection of the true cost of practice than old SMS data and consequently, the AAO-HNS strongly supports the proposal as written.

The use of this survey data is critical for several reasons:

- 1) CY2010 is the final year of a transition to a new practice expense payment methodology. It is appropriate that CMS now use the accurate practice expense data as collected by the PPIS survey.
- 2) MedPAC and the GAO have been calling for CMS to update practice expense payments for several years. In 2006, MedPAC stated that “the data source CMS uses to estimate total practice costs is dated and may not reflect the current practice patterns. Up-to-date and accurate data is needed for all specialties.”
- 3) Utilization of previous data from a small group of organizations has caused distortions and misallocations of practice expense payments. Attempts by other organizations to call for the blending of existing data with the new data will only serve to continue these distortions and misallocations.

The PPIS collected data in a uniform fashion and followed CMS standards. We strongly urge CMS to utilize this data, as it is the most precise data available and will ensure accurate practice expense payments across the system.

Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, CMS adopted an equipment usage assumption of 50 percent. MedPAC addressed this issue in previous reports and again in its March 2009 Report to Congress. In part of its discussion, MedPAC summarized the results of a survey of imaging providers and concluded that the CMS assumption is significantly understated.

In the proposed rule, CMS agrees with the MedPAC findings and notes that all of the equipment cited in the studies is priced over \$1 million. Therefore, CMS proposes to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over \$1 million. We believe the CMS assumption is consistent with the MedPAC findings and we support the CMS proposal.



Malpractice Relative Value Units (RVUs)

Initial implementation of resource-based malpractice RVUs occurred in 2000. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule. In this current rule, CMS proposes to implement the second review and update of malpractice RVUs.

For the CY 2010 fee schedule, CMS proposes to use: (1) CY 2006 and CY2007 malpractice premium data from 49 States and the District of Columbia for all physician specialties represented by major insurance providers; (2) CY 2008 Medicare payment data on allowed services and charges; and, (3) CY 2008 geographic adjustment data for malpractice premiums. In addition, CMS proposes to use the malpractice premium rates of medical physicists as a proxy (in the absence of actual premium data) to develop malpractice RVUs for technical component services and other services with no physician work.

In general, we support the proposed methodology for calculating malpractice RVUs for those services and procedures for which there is physician work. The use of current premium data collected from a larger number of specialties is appropriate. However, we are concerned about certain aspects of the CMS proposal to crosswalk 13 specialties for which there was not significant premium data available (those in less than 35 States' malpractice premium rate filings) to similar specialties and risk classes. Specifically, as shown in Table 4 of the proposed rule, CMS proposes to crosswalk the specialties of oral surgery and maxillofacial surgery to the specialty of allergy/immunology. We believe it is illogical to crosswalk the premium data for a medical subspecialty like allergy/immunology to any surgical specialty. We recommend that CMS use the malpractice premium data from the American Association of Oral and Maxillofacial Surgeons (AAOMS) that was provided to CMS by the RUC in a letter dated January 9, 2008. Actual premium data of \$15, 948 is clearly preferable to the proposed crosswalk to an unrelated specialty.

For those services and procedures with zero work RVUs, we are concerned that the methodology results in the inappropriate assignment of zero malpractice RVUs for a large number of services that are commonly performed by our members in their offices. In particular, we are concerned codes about the codes with zero malpractice RVUs in the following sections of CPT: Audiologic Function Tests (92551-92597), Allergy Testing (95004-95075) and Allergen Immunotherapy (95115-95199)

We note that during the 18 years the physician fee schedule has been in place, no service for which payment has been made has ever been assigned zero malpractice RVUs. We acknowledge that the malpractice expenses for some services are not high but they are never zero. We strongly urge CMS to assign the lowest possible value of 0.01 RVUs to those services for which zero malpractice RVUs have been proposed.



Coding Issues

Canalith Repositioning

In 2008, the CPT Editorial Panel created a new code for canalith repositioning (CRP), a treatment for vertigo. In the CY 2009 PFS final rule new CPT code 95992, Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day, was assigned the bundled status indicator (B). AAO-HNS, the American Academy of Neurology (AAN), the American Physical Therapy Association (APTA), and other organizations expressed strong opposition to the decision to bundle this new code for which the RUC had recommended 0.75 work RVUs.

In the proposed rule, CMS did not acknowledge or respond to the comments submitted by AAO-HNS and other physician specialty societies. Rather, CMS responded to the comments of the APTA and clarified that therapists should use one of the existing physical therapy codes such as CPT code 97112.

We are compelled by CMS' failure to address our concerns by re-stating them in this comment letter. When this code was created, the procedure itself was often billed using a variety of codes. When a code does not exist for a service, physicians may bill with an unlisted code or decide not to bill for it at all, given the extensive administrative burden to collect for an unlisted code. Previous CMS statements that the procedure was being paid for as part of an E&M are simply inaccurate.

Performing the canalith repositioning procedure is a skill similar to the performance of a lumbar puncture or minor surgical procedure. It is unfair and unrealistic to expect physicians to forgo reimbursement when they apply clinical skills to a service that takes an extra 20-30 minutes to perform. It is not an inconsequential amount of time and effort that goes into performing this procedure and it is not appropriate policy to state that the code is inactive or bundled.

Physicians who are providing this service to their patients, such as otolaryngologists who have specialized in neuro-otology, must take the time for an office visit to interview and examine the patient, then perform the procedure. By bundling the canalith repositioning service into the E&M, Medicare is only compensating the physician for half of the work they performed.

In accordance with CPT and CMS documentation guidelines, performing canalith repositioning does not count toward the Counseling and Coordination of Care basis for coding using time as a measure of the service, because it is a treatment. Because physicians cannot account for additional time to perform this procedure during an office visit, we believe it is unfair to bundle the time for this procedure into an E/M service and provide no reimbursement for the extra time spent performing the procedure during this time period. In addition, it is contrary to CPT coding principles to suggest that therapists



should bill using CPT code 97112 when a CPT code that accurately describes the service exists.

AAO-HNS encourages CMS to revise this decision. It is based on an inaccurate assumption and is contrary to coding principles. The canalith repositioning procedure is a safe, valid, and very important service to provide to affected Medicare beneficiaries, and should be reimbursed by Medicare in accordance to the time and effort spent by physicians on this procedure.

Audiology Codes: Policy Clarification of Existing CPT Codes

In the CY 2009 PFS final rule, CMS accepted the RUC recommended work RVUs for 6 audiology codes (CPT codes 92620, 92621, 92625, 92626, 92627, and 92640). CMS also noted that in the Medicare program, audiology services are provided under the diagnostic test benefit and that some of the work descriptors for these services include “counseling,” “potential for remediation,” and “establishment of interventional goals.” Since audiology services fall under the diagnostic test benefit, aspects of services that are therapeutic or management activities are not payable to audiologists.

CMS received comments from the society that represents speech language pathologists, audiologists, and speech and language scientists objecting to this decision. In the proposed rule, CMS responds to those comments, re-affirming its position and emphasizing that therapeutic and/or management activities associated with these audiology tests are not payable to audiologists because of the benefit category under which these tests are covered. We strongly support this position and wish to express our appreciation for the decision to clarify the policy in the proposed rule, even though no change in policy is proposed. We urge CMS to issue instructions to contractors to monitor these services to prevent inappropriate payments.

Consultation Services

CMS proposes to no longer recognize the billing codes for consultation services (except for telehealth consultations). CMS proposes to assign the work RVUs that were allotted to these services to the work RVUs for new and established office visit services, initial hospital visits, and initial nursing facility visits.

This proposed change would be implemented in a budget neutral manner, meaning it would not increase or decrease PFS expenditures. CMS would make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and by increasing the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. CMS crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits.

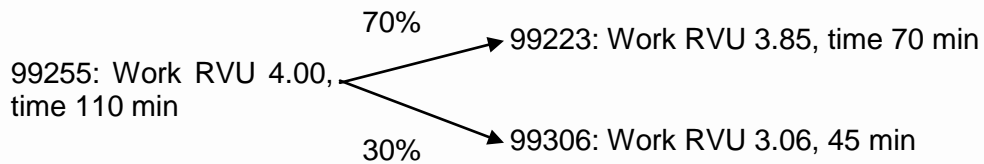


Physicians would bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, CMS would create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier would distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. Subsequent care visits would be reported as subsequent hospital care codes and subsequent nursing facility care codes.

The impact of this proposal is a reduction in payment to those specialties that typically provide consultative services and an increase in payments to those specialties that provide primary care services. We recognize the importance of primary care and support the increased payments that will go to the primary care specialties as a result of the proposals related to practice expense that are described above, along with the other increases attributed to primary care services through the RUC process. We note that the impacts of those proposals on family and general practice are +5 percent while the impacts on internal medicine and pediatrics are + 4 percent. Unfortunately, under the CMS proposal, this amounts to a redistribution of payments of more than \$690 million from other specialties, including otolaryngology.

We support CMS in its effort to reduce the confusion between a consultation and a transfer of care, and we agree that documentation requirements are similar across the codes. However, while we are generally supportive of CMS's goals in this area, we strongly recommend that CMS also make corresponding updates to global procedures to account for the proposed increases in office visit codes. Specifically, we ask that CMS extend the proposed increase to codes 99211-99215 that are built into the 10-day and 90-day global services. Arbitrarily changing the work RVUs for some E/M codes without adjusting the E/M components of other procedure codes undermines the relative value scale on which payments for physicians are based.

We also have concerns about CMS's approach to the crosswalk of consultation codes to E/M codes. As stated in section 1848(c)(1)(A): "The term 'work component' means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." The original Harvard RBRVS study clearly demonstrated that the work of consultations differs from the work of office and hospital visits. Those findings have been affirmed many times by CMS since the fee schedule was implemented in 1992, most recently with the completion of the third 5-year review of work in 2007. Yet, according to the CMS crosswalk, 70 percent of the highest level of inpatient consultation (99255) would be reported as the highest level of inpatient hospital care (99233) and 30 percent as the highest level of nursing facility care (99306). The differences in physician work and physician time for these three services are clearly shown in the table below:



In the face of these clear differences, we simply do not understand how CMS can now assert that the physician work is “clinically similar.”

We have concerns about CMS’s plans to implement this proposal on January 1, 2010. This is a significant change to the coding practices of numerous specialists, and it will be difficult to educate our members in such a short period of time. A significant increase in denials and appeals will be likely. Like other surgical specialty societies, we have concerns about how this change will impact the billing and payment practices for private payers, particularly in terms of Medicare secondary, cross-over claims. Otolaryngology is already experiencing significant, and similar, issues with cross-over claims in terms of the audiology transmittals issued in February 2008. We urge CMS to engage private payers in a discussion about how this proposal would affect that process. We believe that such a coordinated discussion would ease implementation and reduce the administrative burden and confusion for physician practices.

In summary, the AAO-HNS generally supports the principles behind CMS’s proposal, and we request that you give careful consideration to the concerns we have delineated.

Potentially Misvalued Services Under the Physician Fee Schedule

This section of the proposed rule includes a summary of the efforts of the American Medical Association’s (AMA) Relative Value System Update Committee (RUC) to identify potentially misvalued services. Included in those efforts was the identification of site of service anomalies, i.e., procedures that typically were performed in the past in the inpatient hospital setting but now are more commonly performed in an outpatient hospital or ASC setting.

In the CY 2009 PFS final rule, CMS noted that although they would accept the RUC valuation for site of service anomaly codes for 2009, they had concerns about the methodology used by the RUC to review these services which may have resulted in removal of hospital days and deletion or reallocation of office visits without extraction of the associated RVUs from the valuation of the code. In this proposed rule, CMS proposes further changes to several of the codes where the valuation has been adjusted to reflect changes in the site of service. Specifically, CMS proposes changes to codes for which the RUC review process deleted or reallocated pre-service and post-service times, hospital days, office visits, and discharge day management services.



We strongly oppose this proposal which employs a methodology for calculating work RVUs that lacks validity on its face. Specifically, CMS acknowledges that its calculations would result in negative RVUs for several codes. We also note that the methodology results in increased RVUs for several codes which is clearly an unexpected outcome of an exercise intended to revalue “overvalued” services. We recommend that CMS maintain the current RVUs that are based on recommendations from the RUC that were accepted by CMS for CY 2009.

For “23-Hour” stays, CMS requests that the AMA RUC include the additional time associated with the patient evaluation and assessment in the post-service period in their recommendations to CMS. CMS states they will not allow an additional E/M service to be billed for care furnished during the post-procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay. We strongly oppose this proposal which appears to reflect a misunderstanding of clinical practice for patients who require an overnight stay in the hospital after surgery. These patients must be evaluated by their surgeon the following morning before discharge and that evaluation requires physician work that must be recognized in determining the appropriate work RVU. The work involved for the physician is the same regardless of whether the patient is classified as “inpatient” or “observation”. We urge CMS to continue to work with the RUC on a methodology for reviewing those procedures that typically require 23-hour stays.

CMS seeks comment on the MedPAC recommendation to establish a panel of experts separate from the AMA RUC to review RVUs. CMS indicates that this recommendation was intended not to supplant the AMA RUC but to augment it. MedPAC suggested that the panel should include members who do not directly benefit from changes to Medicare’s payment rates, such as experts in medical economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers. We strongly oppose the creation of an independent panel of experts. We view such a panel as an unnecessary duplication of the RUC that is unlikely to add value to the process. Further, we view it as an unnecessary expense at a time of diminished financial resources for administering the Medicare program.

Proposed Conversion Factor Update for 2010 and the Sustainable Growth Rate (SGR)

Updates to Medicare physician payments are made each year based on a statutory formula established in section 1848(d) of the Social Security Act. The calculation of the Medicare physician fee schedule update utilizes a comparison between target spending for Medicare physicians’ services and actual spending. The update is based on both cumulative comparisons of target and actual spending from 1996 to the current year, known as the Sustainable Growth Rate (SGR), as well as year-to-year changes in target and actual spending. The use of SGR targets is intended to control the growth in aggregate Medicare expenditures for physicians' services.



Despite the intended incentives, actual spending under the SGR system has deviated significantly from target spending. In a March 1, 2009 letter from CMS to the MedPAC, CMS estimated the difference between cumulative target and actual spending from the 1996/1997 base year through December 2009 at \$69.7 billion. CMS estimated the PFS update would be -21.5 percent for CY 2010. We continue to be deeply concerned about the impact of the sustainable growth rate (SGR) formula on payments for physician services under the fee schedule. There is no question that a cut of 21.5 percent would adversely affect the quality of care and beneficiary access to physicians' services.

To address these problems, we support the provisions of proposed H.R. 3200 – America's Affordable Health Choices Act of 2009 that would:

- repeal the SGR and provide an MEI update for 2010 instead of a 21.5% cut;
- eliminate all SGR debt accumulated after years of temporary, unfunded fixes;
- establish two new expenditure targets with significantly higher utilization growth allowances than the SGR;
- exclude the cost of physician-administered drugs and laboratory services from the new targets; and,
- re-set the new targets after five years to help reduce the likelihood of future steep cuts under the new targets.

We were pleased to note the CMS proposal to revise the definition of physicians' services for purposes of the SGR in the 2010 proposed rule for the physician fee schedule. Under the Medicare Volume Performance Standard (the predecessor to the SGR system), CMS defined "physicians' services" to include physician-administered drugs. Such drugs have remained under the SGR ever since. At the time CMS made the decision to include physician-administered drugs in the definition of "physicians' services" used to compute the SGR, these drugs represented a much smaller volume of Medicare spending than they have in subsequent years.

Given the significant and disproportionate impact that the inclusion of drugs has had on the SGR system, CMS now believes it would be appropriate to revise the definition of physicians' services for purposes of the SGR. CMS concludes that the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of "physicians' services."

As the statute affords the Secretary discretion, CMS proposes, in anticipation of enactment of legislation to provide fundamental reforms to Medicare physician payments, to remove physician-administered drugs from the definition of "physicians' services" for purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years. Moreover, given the past effect of spending growth for physician-administered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of "physicians' services" CMS also proposes to remove drugs from the calculation of allowed and actual expenditures for all prior years. We commend CMS for these proposals and we offer our strong support.

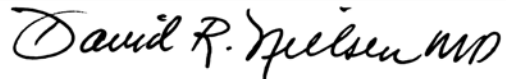


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Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide these comments and recommendations on behalf of our members. If you require further information, please contact Tricia J. Bardon, Assistant Director, Health Policy by telephone at (703) 535-3725 or through e-mail at TBardon@entnet.org.

Sincerely,



David R. Nielsen, MD
Executive Vice President and CEO