



August 23, 2010

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1503–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 Revisions to Part B for CY 2011; Proposed Rule (CMS–1503–P)

Dear Dr. Berwick:

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 Revisions to Part B for CY 2011” published in the Federal Register as a proposed notice on July 13, 2010. Our comments will address the following issues, in the order in which they appear in the proposed rule: (1) elimination of consultation codes; (2) the sustainable growth rate (SGR); (3) resourced-based practice expense relative value units (PE RVUs); (4) proposed PE revisions for CY 2011; (5) potentially misvalued codes under the PFS; (6) expansion of the multiple procedure payment reduction (MPPR) policy; (7) high cost supplies; (8) refinement panel process; (9) rebasing and revising the Medicare Economic Index (MEI); (9) coding issues, including Canalith Repositioning; (10) Physician Quality Reporting Initiative (PQRI); (11) value-based payment modifier; and (12) disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services.

Elimination of E&M Consultation Codes

In the preamble to the proposed rule, CMS mentions the elimination of consultation codes and urges the public to provide feedback on how they can improve their payment methodology. AAO-HNS surveyed its members about the impact of the elimination of consultation codes on their practices. Among the otolaryngologist – head and neck surgeons who completed the survey, 57 percent reported they have experienced a more than 20% loss in their total revenue because of the elimination of the consultation codes. This reduction has resulted in concern for treating patients with complex conditions and could lead to fewer Medicare patients obtaining care through the specialty. ***The AAO-HNS is apprehensive about the possible negative consequences on patients’ access to care. We welcome the***

2009-2010 ACADEMY BOARD OF DIRECTORS

OFFICERS

Ronald B. Kuppersmith, MD, MBA
President
College Station, TX

J. Regan Thomas, MD
President-Elect
Chicago, IL

John W. House, MD
Secretary/Treasurer
Los Angeles, CA

David R. Nielsen, MD
Executive Vice President and CEO
Alexandria, VA

IMMEDIATE PAST PRESIDENT

David W. Kennedy, MD
Philadelphia, PA

AT-LARGE DIRECTORS

Stephen J. Chadwick, MD
Decatur, IL

Terry A. Day, MD
Charleston, SC

Donald C. Lanza, MD, MS
Saint Petersburg, FL

Thomas B. Logan, MD
Henderson, KY

James L. Netterville, MD
Nashville, TN

James A. Stankiewicz, MD
Maywood, IL

J. Pablo Stolovitzky, MD
Atlanta, GA

Debara L. Tucci, MD
Durham, NC

BOARD OF GOVERNORS

Gavin Setzen, MD
Chair
Albany, NY

Michael D. Seidman, MD
Chair-Elect
West Bloomfield, MI

Jerry M. Schreibstein, MD
Immediate Past Chair
Springfield, MA

COORDINATORS

Lee D. Eisenberg, MD, MPH
Governmental Relations
Englewood, NJ

Rodney P. Lusk, MD
Internet and Information Technology
Omaha, NE

Michael Setzen, MD
Practice Affairs
Great Neck, NY

Richard W. Waguespack, MD
Socioeconomic Affairs
Birmingham, AL



opportunity to work with CMS on other alternatives to compensate for the impact of the elimination of consultation codes on otolaryngologists. Needless to say, the most straightforward solution to the problems created by the elimination of the consultation codes would be to restore their use as soon as possible.

The Sustainable Growth Rate (SGR)

The volatility and instability of the Medicare payment system is threatening Medicare beneficiaries' access to care. Three times this year, Congress failed to stop Medicare cuts of over 21 percent from taking effect. While Congress eventually rescinded the payment cuts retroactively, physicians now have the additional administrative task of contacting Medicare carriers to ensure that they receive the appropriate payment for the care they provided to patients. Additionally, multiple interruptions to cash flow have created major upheaval in physician offices and clinics and disrupted financial management. On December 1, 2010, Medicare payments for all physician services are scheduled to be cut more than 23 percent as a result of Medicare's flawed SGR formula. One month later, on January 1, 2011, Medicare payments are scheduled to be cut by an additional 6 percent, producing cuts of more than 30 percent from current levels.

These continued payment cuts, rising practice costs and a lack of certainty going forward, make it difficult, if not impossible, for already financially challenged otolaryngologist – head and neck surgeon practices to continue to treat Medicare patients. A February 2010 survey conducted by the Surgical Coalition confirms that surgeons and anesthesiologists will be forced to make significant changes in their practices if Medicare payments continue to decline, jeopardizing timely access to surgical care. The survey found:

- Thirty-seven percent of respondents will change their Medicare status to “nonparticipating” and an additional 29% will opt out of Medicare altogether.
- Those remaining in Medicare will also make significant changes to their practices, with 69% limiting the number of Medicare patient appointments; 47% reducing time spent with Medicare patients; and 45% no longer providing certain services.
- A direct connection between Medicare payment cuts, jobs and the economy, as 43% of respondents stated they would reduce staff; 44% would defer the purchase of new medical equipment; and 32% would defer purchases of health information technology.

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 potential cut of more than 30 percent would adversely affect the quality of care and beneficiary access to physicians' services. We believe CMS should take additional administrative actions similar to the 2010 decision to exclude physician-administered drugs



from the definition of “physicians’ services.” This would help to reduce the cost of eliminating the SGR formula, We recommend that CMS convene a meeting of physician specialty societies and other of stakeholders to identify reasonable and appropriate administrative changes that could be implemented as soon as possible. We believe the goal of eliminating the flawed SGR formula will not be met without a commitment by CMS to reduce administratively the cost of needed legislation.

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

Physician Practice Information Survey (PPIS)

CMS indicates that CY 2011 will be the second year for the transition from Practice Expense data developed from the PPIS. Therefore, the Practice Expense (PE) RVUs in the CY 2011 MPFS will be a 50/50 blend of PE data from the AMA Socioeconomic Monitoring System (SMS) and that of the PPIS. ***The Academy continues to support the decision by CMS to utilize the PPIS data as we believe it is the most precise and accurate data available.***

Equipment Utilization Assumption Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, CMS proposes to apply a 75 percent utilization rate for expensive imaging equipment (i.e. equipment valued over \$1 million) in a non-budget neutral process for CY 2011 based on the requirements included in the Affordable Care Act of 2010 (ACA). CMS further explains that the changes to the PE RVUs will not be transitioned over a period of years. CMS is proposing to add 24 additional codes to the 75% utilization rate, including diagnostic computed tomographic angiography and magnetic resonance angiography (MRA) procedures. ***As in our comment letter last year on the NPRM CY2010 MPFS, we support CMS’ proposal to apply the 75 percent utilization rate for these procedures.***

Proposed PE Revisions for CY 2011

Updating Equipment and Supply Inputs for Existing Codes

Rather than updating PE price inputs on an ad hoc basis, CMS proposes to collect requests to update the PE price inputs for supplies and equipment from the public on an ongoing basis and include these requests in the proposed and final rules. The NPRM further provides a deadline of December 31st of the CY for these requests to be included in the NPRM. CMS’ rationale for this proposal is to establish a regular and more transparent process.

The Academy is generally supportive of this proposal but we have some concerns about the ability of the process to make timely corrections to significant but unintended errors in the current database that are brought to the attention of CMS by specialty societies or other stakeholders. We



recommend that CMS allow for an exception to the use of the rule-making process for significant errors. When such errors are brought to the attention of CMS, we recommend that they be sent to the RUC for review and comment. If it is agreed that there is an error in the database and that it is of such significance that waiting for one year or more for it to be corrected would result in inequitable payments, we believe CMS should incorporate the new data into the calculation of the PE RVUs and issue a correction in the next quarterly update of the physician fee schedule database.

PLI RVUs for New and Revised Services Effective Before the Next 5-Year Review

In order to try to be more transparent, CMS plans to publish a list of new/revised codes and the analytic crosswalks they used to determine their professional liability insurance (PLI) RVUs in the final rule with comment period. CMS plans to implement these PLI RVUs as interim final values in the CY 2011 MPFS final rule with comment period, allowing for public comment and finalizing these values in the CY 2012 MPFS final rule. ***We appreciate that CMS is working to make the methodology more transparent and support the proposed decision to publish the PLI RVUs on an interim basis and to provide the opportunity for public comment. We respectfully recommend that the source of the PLI values be explicitly stated in the final rule and that the final rule include a description of the methodology and rationale for the interim values.***

Potentially Misvalued Services under the PFS

The ACA requires the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to their relative values. Specifically, the ACA directed the Secretary to specifically examine potentially misvalued services in seven categories.

1. Codes and families of codes for which there has been the fastest growth.
2. Codes or families of codes that have experienced substantial changes in practice expenses.
3. Codes that are recently established for new technologies or services.
4. Multiple codes that are frequently billed in conjunction with furnishing a single service.
5. Codes with low relative values, particularly those that are often billed multiple times for a single treatment.
6. Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes').
7. Other codes determined to be appropriate by the Secretary.

Over the last several years, CMS, in conjunction with the AMA RUC, has identified and reviewed numerous potentially misvalued codes in all seven of the categories. The Academy has been and continues to be actively involved in surveying its



members and providing recommendations to the AMA RUC for otolaryngology associated codes.

In addition to requiring the identification and review of potentially misvalued codes, the ACA directs the Secretary to establish a formal process to validate relative value units under the PFS. CMS intends to establish a more extensive validation process of RVUs than the assessment of AMA RUC recommended work RVUs under the existing processes. In the proposed rule, CMS solicits comments on possible approaches and methodologies that should be considered for a validation process with a special interest in the use of time and motion studies. CMS is interested in validating estimates of physician time and intensity that are factored into the work RVUs for services with rapid growth in Medicare expenditures.

We strongly disagree with this untested approach as we believe that it devalues the RUC input and process, which the Academy supports. In addition, properly conducted time and motion studies are extraordinarily expensive to conduct properly. With thousands of codes on the fee schedule, it is unlikely that all the codes could be studied. This would lead to the work RVUs of some codes being based on time and motion studies with the vast majority of the work RVUs being based on traditional magnitude estimation. We would view this as inequitable and therefore oppose the consideration of time and motion studies as the basis for physician work RVUs. In addition, a focus on time would likely diminish the importance of varying degrees of work intensity which would be contrary to common sense, the Harvard RBRVS study and 20 years of work by CMS, the RUC and physician specialty societies.

Codes with Site-of-Service Anomalies

Over the past several years, CMS requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. This activity is a component of the agency's ongoing efforts to identify potentially misvalued codes. For example, CMS has identified services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to the outpatient setting. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, CMS believes it is reasonable to expect there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the proposed rule, CMS reviewed the history of these codes, expressing the agency's disagreement with some aspects of the AMA RUC's review process and its disagreement with some of the AMA RUC's previous recommendations. CMS



explained the “reverse building block” methodology they used for this proposed rule to re-evaluate the work RVUs for the 29 codes previously reviewed for CY 2009 and the 11 codes previously reviewed for CY 2010. CMS acknowledged previous comments that pointed out that the CMS methodology can produce work RVU results that are considerably reduced or even negative. Rather than conceding that this could indicate a problem with its methodology, CMS states their belief that the negative results are an indication that the original work RVUs were not valued correctly.

We are concerned about the otolaryngology codes 42415 and 42420 that CMS identified under the site-of-service anomaly category. CPT codes 42415, Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve and 42420, Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. At the April 2008 RUC Meeting, we presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

We presented data from a survey of 76 otolaryngologists and general surgeons as well as consensus recommendations from an expert panel of otolaryngologists and general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following these procedures. The survey results indicated that 97% of respondents perform the procedure in the hospital and that more than 90% of the patients stay overnight.

For code 42415, we presented data that one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the survey results regarding physician time and post-operative visits. The RUC recommended the new physician times as well as hospital and office visits, but recommended maintaining the current work RVU of 17.99 for CPT code 42415. In the 2010 final rule, CMS agreed with this recommendation.

For code 42420, we presented data that one 99231 hospital visit, one 99232 hospital visit, one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the survey results regarding physician time and post-operative visits and recommended the new physician times as well as hospital and office visits, but recommended maintaining the current work



RVU of 20.87 for CPT code 42420. In the 2010 final rule, CMS agreed with this recommendation.

Despite the overwhelming evidence collected in accordance with the principles of magnitude estimation, CMS proposes to reduce the work RVUs of these two procedures based on a faulty and illogical reverse building block methodology. The Academy strongly believes that the CMS methodology is totally inconsistent with magnitude estimation, the method established by the original Harvard RBRVS Study in the late 1980s and employed by CMS and the RUC for the past 20 years.

We reviewed the description of the reverse building block methodology in the proposed rule and will comment on the sample calculation that CMS presents for code 21025 Excision of bone (e.g., for osteomyelitis or bone abscess); mandible). CMS lists the original inputs for this code and shows a calculated Intra-Service Work per Unit of Time (IWPUT) of 0.0145. This low value is inconsistent with the work of a major surgical procedure and should have been recognized by CMS as an indication that the code was likely undervalued when the original inputs were developed. As a point of comparison, the IWPUT of a midlevel office visit (code 99213) is 0.0527, nearly 4 times the IWPUT for code 21025.

We note that IWPUT is a calculated figure that starts with the total work RVUs, subtracts the work of post-operative visits in the follow-up global period as well as the pre-service and immediate post-service work on the day of the procedure. The work in the pre-service and immediate post-service period is a calculated value based on an assumption that the intensity of work during these periods is 0.0224 RVUs per minute. Thus, 75 minutes of pre-service time and 43 minutes of post-service time corresponds to 1.68 work RVUs in the pre-service period and 0.96 work RVUs in the immediate post-service period.

As described in the proposed rule, CMS determined a revised intra-service work RVU for code 21025 by multiplying the starting IWPUT value of 0.0145 by 30 minutes (the difference between 120 minutes of intra-service time in the original valuation and 90 minutes of intra-service time in the 2008 survey of this code for the RUC). CMS notes in Table 14 of the proposed rule that this results in subtracting 0.44 work RVUs from the original calculation of intra-service work. What CMS does not show or explain is that under their reverse building block methodology, the new intra-service work is 1.30 work RVUs. As a point of reference, the work RVUs for a 25 minute office visit (code 99214) is 1.50. Thus, under the reverse building block methodology, 90 minutes of operative time is valued lower than 25 minutes of an office visit. This inflammatory result is partly due to the CMS decision to carry forward the original IWPUT into their calculations and apply this figure to the new intra-service time obtained through surveys of physicians. We contend that the work RVUs recommended by the RUC which were based on the survey responses of practicing surgeons has significantly more validity than the results of CMS' contrived reverse building block methodology.



We used the traditional magnitude estimation methodology to review codes 42415 and 42420. We demonstrated that the procedures are not overvalued. We strongly oppose the proposed reductions in work RVUs for these codes that are based on a flawed “reverse building block” methodology. We recommend maintenance of the current work RVUs for CY 2011.

Expansion of the Multiple Procedure Payment Reduction (MPPR) Policy

CMS also proposes to reduce by 50 percent the Practice Expense (PE) component for subsequent “always therapy” services performed on patients in a single **day** (Medicare will fully reimburse the code with the highest RVU but will reduce the PE input for the subsequent codes by 50 percent). CMS’s rationale for doing so is that when these services are performed during the same session, the same supplies and clinical labor are used in the intra-service work for the codes.

The Academy objects to this proposal which fails to account for the fact that the efficiencies that CMS identifies are already built into the practice expense inputs for these codes. It was well understood by the RUC HCPAC Review Board and the RUC’s Practice Expense Subcommittee during the valuation process that multiple units of service would be reported on the same date of service. When the practice expense inputs for the therapy codes were developed, the “typical visit” was defined as a 45 minute visit during which the patient receives two 15 minute therapeutic procedures (e.g., code 97110 Therapeutic exercises to develop strength and endurance, etc. and code 97112 Neuromuscular reeducation of movement, balance, coordination, etc.) and a modality (e.g., code 97032 manual electrical stimulation). In general, the clinical activities for the activities that CMS considers duplicative were halved for the therapeutic procedures and set at zero for the modalities.

In 2010, several of the codes used frequently by therapists were examined by a joint CPT/RUC group to determine whether there is duplication in work and practice expense values. Specifically, the following high volume CPT code pairs were identified and carefully reviewed by the CPT/RUC group in April 2010: 97016, 97110; 97018, 97110; and 97116, 97110. In its April 28th 2010 report, the CPT/RUC workgroup determined that “these services include no duplication in physician work and PE components as these services were valued with limited pre and post time because it was assumed that they would be reported together on the same date by the same physician.”

We recommend that CMS withdraw its proposal to apply a MPPR policy to the therapy codes since the codes are already valued to reflect the efficiencies associated with providing multiple services during a single session.



High Cost Supplies

CMS proposes to base high cost supply price inputs on the publically available prices listed on the General Services Administration (GSA) medical supply schedule. CMS believes that this publicly accessible database would respond to requests from stakeholders for a more transparent process. The medical community and vendors would have the opportunity to submit prices to the GSA for incorporation into the GSA supply schedule.

We understand the importance of accurately identifying the cost of expensive supplies. However, we are concerned that this specific proposal is not an appropriate alternative because the prices reflected in this supply schedule may not reflect the typical prices that would be available to a typical practicing physician. CMS believes that the prices reflect the “individual item ceiling” prices for a single item purchase, making the GSA medical supply schedule appropriate for estimating the high-cost supply prices for physicians’ office purchases. We disagree with this description, noting that CMS indicates in the proposed rule that the GSA supply schedule is used by the Veteran Administration’s (VA) Health System. We think it is unreasonable to believe that the prices paid by the VA system would be in the range of prices available to individual physician practices

Prices in the CMS supply schedule should reflect the prices typically available to physicians across the country treating Medicare patients. ***The Academy does not believe that the GSA supply schedule can provide such information and therefore requests CMS to withdraw this proposal and consider another alternative to updating high cost supplies. If the GSA supply schedule is to be used we encourage CMS not to rely on it as the sole source of data for pricing expensive supplies.***

Refinement Panel Process

CMS will continue to convene multispecialty refinement panels that assist CMS in reviewing public comments on the interim physician work RVUs for CPT codes and adopting final work values for the following year. The refinement panels include representatives of four groups of physicians: clinicians representing the specialty most identified with the procedures in question; physicians with practices in related specialties; primary care physicians; and contractor medical directors. CMS states that the statistical test used to evaluate the RVU ratings of the individual panel members, an F-test, has become less reliable because CMS believes that physicians in each group have tended to select a previously discussed value rather than independently evaluating the work. Accordingly, CMS is proposing to eliminate the use of the F-test and instead base revised RVUs on the median work value of the panel members’ ratings. CMS also adds that the Agency has the final authority to set the RVUs if policy concerns warrant modifications to the values derived from the refinement process.



We question the need for any change in the current refinement panel process that has been in place for nearly 20 years. The statistical analysis that has been conducted by CMS in the past is intended to eliminate the effect of collusion among panel members. The proposal to use the median result could be impacted by such collusion and we urge CMS to reconsider this proposal. More importantly, we are concerned about the CMS proposal to grant CMS the final authority to set the RVUs if policy concerns warrant modifications to the values derived from the refinement process. A major strength of the current process is that it gives stakeholders a strong incentive to participate, knowing that the outcomes of the process will not be overturned by CMS. ***We oppose this proposal and recommend that the decisions of the refinement panels remain unchanged by CMS.***

Rebasing and Revising the Medicare Economic Index (MEI)

CMS proposes to rebase and revise the Medicare Economic Index (MEI), the input price index used in determining annual updates to the physician fee schedule. The MEI reflects the weighted-average annual price change for the inputs needed to provide physicians' services. The MEI was last rebased in 2003 (68 FR 63239), which updated the cost structure of the index from 1996 data to 2000 data. The current base year for the MEI is 2000, which means that the cost weights in the index reflect physicians' expenses in 2000. The proposed rule would rebase the MEI to reflect appropriate physicians' expenses in 2006, the most recent year for which data are available.

"Rebasing" and "revising" denote different activities. Rebasing refers to moving the base year for the cost structure of an input price index, while revising describes other types of changes such as changing data sources, cost categories, or price proxies used in the input price index. CMS derived the proposed expense categories in the index, along with their respective weights, primarily from data collected in the 2006 AMA Physician Practice Information Survey (PPIS) for self-employed physicians and selected self-employed non-Medical Doctor (non-MD) specialties. It included data from the following specialties in the MEI cost weight calculations (optometrists, oral surgeons, podiatrists, and chiropractors) consistent with the definition of the term "physician" in section 1861(r) of the Act.

These are the major changes proposed in the MEI for 2011:

- remove all costs related to drug expenses since drugs are not paid under the PFS and they are not included in the definition of "physicians' services" for purposes of the Sustainable Growth Rate (SGR);
- remove costs associated with separately billable supplies; and
- revise the cost categories in the MEI by expanding the Office Expense category into nine detailed categories with additional price proxies associated with these categories.



These proposals seem reasonable but we note that CMS proposes to convene a technical advisory panel later this year to review all aspects of the MEI, including the inputs, input weights, price-measurement proxies, and productivity adjustment. The panel's analysis and recommendations will be considered in future rule making to ensure that the MEI accurately and appropriately meets its intended statutory purpose. ***We commend CMS for announcing the intent to convene a technical advisory panel to review all aspects of the MEI. In general, we are supportive of the proposed MEI revisions and it would be our preference that the revisions occur in 2011. However, we are concerned that CMS is proposing changes prior to convening the technical advisory panel. We are also concerned that the MEI revisions may harm some specialties. Therefore, the Academy recommends that CMS delay implementation of the proposed MEI revisions and that these proposals be included on the agenda of the upcoming technical advisory panel. If CMS decides to delay the MEI revisions, we respectfully request that the result would not negatively impact any specialty due to the delay.***

As it did when the MEI was rebased for CY 1999 and CY 2004, CMS proposes to make adjustments to ensure that estimates of aggregate CY 2011 PFS payments for work, PE, and PLI are in proportion to the weights for these categories in the rebased CY 2011 MEI. CMS proposes to increase the PE and PLI RVUs by 16.8% and 41.3%, respectively and, to maintain budget neutrality, to adjust the conversion factor downward by applying a .921 factor. The proposed rule adjusts the conversion factor rather than the work RVUs because many commenters have previously cited stability in the work RVUs in requesting that any required budget neutrality adjustments not be made directly to the work RVUs.

We support the CMS proposal to maintain budget neutrality through an adjustment of the conversion factor rather than the work RVUs. However, we oppose rebasing of the MEI in 2011 because, as noted above, CMS proposes to convene a technical advisory panel later this year to review all aspects of the MEI. We recommend a delay in implementation of the rebased MEI pending the review of any recommendations that the panel might make.

Code Specific Issues

Canalith Repositioning

CMS proposes to reverse current policy and pay separately for Canalith Repositioning (CPT 95992), at the RUC's previously recommended work RVUs (0.75) and PE inputs. The new policy would be effective January 1, 2011. Since physicians or therapists can perform the code under or outside a therapy plan of care, CMS plans to assign the code as a "sometimes therapy" code. The Canalith Repositioning procedure is a safe, valid, and very important service to provide to affected Medicare beneficiaries and we greatly appreciate the decision to reimburse



physicians in accordance to the time and effort spent by physicians on this procedure. ***We would like to thank CMS for taking our previous comments into consideration and we strongly support the CMS's decision to separately reimburse Canalith Repositioning (CPT code 95992).***

Physician Quality Reporting Initiative

ACA extends PQRI incentive payments at 1.0 percent for 2011 and 0.5 percent for 2012 through 2014. Beginning in CY2015, the program will be mandatory and providers will be penalized for not participating. ***We are committed to providing the highest quality care to patients and are actively involved in developing evidence-based and clinically relevant quality measures. To be successful, however, we strongly believe that performance measurement should be non-punitive and transparent.***

Value-based Payment Modifier

CMS describes its plans for the next phase of the implementation of the value-based payment modifier required under the ACA, for which CMS intends to seek stakeholder input through rulemaking, open door forums, or other mechanisms. CMS will be developing an episode grouper methodology, and will start publishing the cost and quality measures it intends to use in determining the payment modifier by January 1, 2012. Beginning in 2014, physicians will receive information about the value of care they provide, as reflected by the measures of relative quality and cost. The payment modifier will apply for certain physicians starting in 2015 with all physicians subject to the payment modifier by 2017.

We understand that all stakeholders, particularly patients, benefit from the collection and analysis of physician quality data and that it is important to provide patients, the public and physicians with accurate information on comparative quality performances among providers. Furthermore, meaningful and accurate clinical outcomes and processes of care data must be generated by physicians. ***We continue to be concerned that efficiency measures are not adequately defined and may not contain provisions to assure the level of quality of care, and we strongly recommend that all efficiency measures include appropriate risk adjustment. We appreciate CMS's intent to gather stakeholder input and we look forward to providing CMS with the otolaryngologist perspective.***

Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

Section 6003 of the Affordable Care Act (ACA) imposes on physicians a new disclosure requirement for the in-office ancillary services exception to the prohibition on physician self-referral in the case of designated health services (DHS) consisting of MRI, CT, PET, and any other DHS that the Secretary may specify. Generally,



physicians must provide written notice to a patient at the time of the referral for the designated health service that indicates the service may be provided by other suppliers and that includes a list of some of those suppliers who furnish the DHS in the area where the patient resides.

CMS does not propose any additional DHS that would trigger disclosure under the ACA requirement but solicits comments on whether other radiology and imaging services should be added and the rationale for any such addition. The Academy supports limiting the new disclosure requirements to those required by the statute (MRI, CT and PET).

CMS proposes that suppliers on the list be limited to those located within a 25-mile radius of the referring physician's office, even if the patient resides more than 25 miles away. CMS proposes that there be a minimum of 10 other suppliers on the list but declines to require that the suppliers be closest in proximity to the referring physician. In areas with fewer than 10 suppliers in a 25-mile radius, CMS proposes that the notice include all suppliers in the radius which could in some cases mean none. We support these proposals.

Finally, we endorse the recommendations of the American College of Surgeons for the creation and distribution of an alternate list of providers. We believe that there are other entities, including CMS, Medicare Administrative Contractors (MACs), and accrediting bodies, that are better-situated to possess the information required to be provided to patients under this provision. It is likely that the relevant accrediting bodies have the most complete, up-to-date, and accurate lists of service providers within any given area. We believe that CMS should require these other entities to publish, or provide, an electronic posting of these providers to which physicians could direct their patients as part of this disclosure. Physicians would be able to access these lists to provide to their patients in order to comply with this requirement and obtain a signature that the list was received by the patient. This would also address the issue of construed endorsement by allowing the proper accrediting bodies to offer a current list of suppliers in both the area of the physician's office and the patient's residence as well as alleviate the unnecessary burden of every physician office in the country that provides advanced imaging services to continuously replicate the work of other providers thus creating a vast inefficiency in the health care system. This inefficiency is completely unnecessary given that the work of creating a list of alternate providers could easily be performed by a central authority better able to provide this type of information.

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 Jenna Kappel, MPH, MA, Director of Health Policy at JKappel@entnet.org or 703-535-3724. Thank you.



AMERICAN ACADEMY OF
OTOLARYNGOLOGY—
HEAD AND NECK SURGERY

Sincerely,

David R. Nielsen MD

David R. Nielsen, MD
Executive Vice President and CEO