



The Society for Cardiovascular Angiography and Interventions

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September 4, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1590-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via <http://www.regulations.gov>

Re: Payment Policies Under the Physician Fee Schedule for CY 2013;
Proposed Rule; 77 *Fed. Reg.* 44,722 (July 30, 2012); CMS-1590-P

Dear Acting Administrator Tavenner:

The Society for Cardiovascular Angiography and Interventions (SCAI) is a non-profit professional association with over 4,000 members representing the majority of practicing interventional cardiologists in the United States. SCAI promotes excellence in invasive and interventional cardiovascular medicine through physician education and representation, and the advancement of quality standards to enhance patient care. SCAI having reviewed the “Payment Policies Under the Physician Fee Schedule for CY 2013; Proposed Rule; 77 *Fed. Reg.* 44,722 (July 30, 2012); CMS-1590-P” offers the following comments:

Summary

SCAI commends CMS staff for their dedication and commitment to the continual refinement to the Medicare Physician Fee Schedule (MPFS), which is again evident in the production of this proposed rule. The areas of focus and concern to the interventional cardiology community within this proposed rule are CMS’ proposal to apply the MPPR to the technical component for diagnostic cardiovascular and ophthalmology diagnostic services, which we vehemently oppose; concerns regarding the stratification of physicians by specialty/sub-specialty in regards to the production of cost and quality reports; and, concern in regards to inadequate risk adjustment in cost assessment that will likely lead to some physicians with high cost patients being unfairly mislabeled as over-utilizers. Finally, in review of the value-based modifier proposal, SCAI recommends limiting the value-based modifier to large integrated (or integrating) health systems where hospitals either employ the physicians or have ownership in the physician practices.

Specific Comments

Multiple Procedure Payment Reductions (MPPR) – Low/No Potential for Economies

SCAI strongly opposes CMS proposal to apply a 25 percent multiple procedure payment reduction (MPPR) to the technical component of certain diagnostic cardiovascular and ophthalmology services when these services are furnished by the same physician/physician group, to the same patient, on the same day. CMS’ selection of the services to apply this MPPR is questionable as these services are not found to be commonly performed together and the assumptions made by CMS in regards to potential efficiencies in staff tasks and time are completely inaccurate resulting in a seriously flawed methodology in the calculation of potential efficiencies for these services

The diagnostic services selected are not commonly performed together as CMS has asserted. The AMA RUC has closely examined the frequency at which the identified services are billed together and has found that only a handful of the possible code pairs are typically reported together with all the other possible codes pair combinations being “reported together at or below 40 percent of the time, with over half below 20 percent.”

In evaluating for potential efficiency in the technical component in the performance of these diagnostic tests when provided by the same physician/physician group, to the same patient, on the same day - CMS made the *false* assumption that the following clinical staff activities would *not* be repeated separately for each procedure: Greeting and gowning the patient, Preparing the room, equipment and supplies, Education and consent, Completing diagnostic forms, Preparing charts, Taking history, Taking vitals, Preparing and positioning the patient, Cleaning the room, Monitoring the patient, Downloading, filing, identifying and storing photos, Developing film, Collating data, QA documentation, Making phone calls, Reviewing prior X-rays, lab and echos.

However, careful review of these clinical staff tasks associated with the performance of each of these diagnostic tests finds that there is a very low to absolutely no potential for economy and that these tasks typically would be repeated for each discrete diagnostic test performed.

Staff Activity	Potential for Economy	Rationale
Greeting and gowning the patient	LOW POTENTIAL FOR ECONOMY	Depending on the diagnostic procedure, unique staff types/technicians may be employed in support of performance of the procedure. Technicians often specialize in terms of specific diagnostic testing modalities. Each technician must greet the patient. Additionally, depending on the diagnostic test being performed there may be unique, discrete gowning and/or personal protective apparel provided. Often patients have to move from one area to another for each test, requiring

		changing into “street clothes” in between tests.
Preparing the room, equipment and supplies	LOW POTENTIAL FOR ECONOMY	Diagnostic studies involving different room types and equipment are included on the list. Each room must be discretely prepared. Supplies listed are unique to the diagnostic services being performed – supplies cannot be “reused” in support of performance of a discrete additional diagnostic test.
Education and consent	NO ECONOMY	Each diagnostic procedure is discrete in this regard. One cannot consent a patient for any and every procedure to be done to them in a given day – informed consent must be provided; requiring discrete education and consent to be provided for each diagnostic procedure performed.
Completing diagnostic forms	NO ECONOMY	Two discrete tests require the completion of unique forms specific to the procedure being provided.
Preparing charts	LOW POTENTIAL FOR ECONOMY	Each diagnostic test requires the addition of unique documentation in the patient’s medical record. While certainly, there should be one primary chart created for the patient, the staff times presented in conjunction with preparing charts do NOT reflect the creation of a new patient chart; the time afforded supports staff time for additions to the patient medical record associated with the performance of the diagnostic test. Each test must be discretely documented in the patient medical record.
Taking history	LOW POTENTIAL FOR ECONOMY	Depending on the diagnostic procedure, unique staff types/technicians may be employed in support of performance of the procedure. Technicians often specialize in terms of specific diagnostic testing modalities. Each technician must familiarize themselves with the patient’s history as it relates to the specific diagnostic procedure being performed.
Taking vitals	LOW POTENTIAL FOR ECONOMY	Depending on the diagnostic procedure, unique staff types/technicians may be employed in support the performance of the procedure. Typically, each technician takes vitals prior to performance of the procedure. Vital signs usually change between the time of one test and the time of the next test.
Preparing and positioning the patient	NO ECONOMY	Preparing and positioning are discrete services dependent upon the diagnostic procedure being performed.
Cleaning the room	LOW POTENTIAL FOR	Many of the diagnostic procedures listed require unique room types for their

	ECONOMY	performance, requiring each room to be cleaned.
Monitoring the patient	NO ECONOMY	The time spent monitoring the patient is directly variable depending on the number and types of tests performed. The diagnostic tests listed are temporally, discretely performed.
Downloading, filing, identifying and storing photos	NO ECONOMY	Each diagnostic tests provides its' own data. The inclusion of photos in the patient's medical chart would be discretely associated with the diagnostic procedure being performed.
Developing film	NO ECONOMY	The development of film for the patient's medical chart would be discretely associated with the diagnostic procedure being performed. Each diagnostic tests provides its' own data.
Collating data	NO ECONOMY	The inclusion of data from the diagnostic for the patient's medical chart would be discretely associated with the diagnostic procedure being performed. Each diagnostic tests provides its' own data to be incorporated into the patient medical record.
QA documentation	NO ECONOMY	QA documentation requirements would be specific to the individual diagnostic test being provided. Each diagnostic tests provides its' own QA documentation to be incorporated into the patient medical record.
Making phone calls	LOW POTENTIAL FOR ECONOMY	While certainly not as many phone calls may be required, the length of the phone call would be directly variable to the number of diagnostic tests being performed.
Reviewing prior X-rays, lab and echos	LOW POTENTIAL FOR ECONOMY	Depending on the diagnostic procedure, unique staff types/technicians may be employed in support of performance of the procedure. Typically, each technician must familiarize themselves with prior X-rays, labs, and echos.

SCAI does not believe the proposed application of the MPPR to the technical component for a select, targeted subset of diagnostic tests is in the best interest of patients. There is grave concern that such a reduction in value for these services will drive these diagnostic tests to the more expensive hospital outpatient setting. Physicians who are able to schedule multiple diagnostic tests on the same date of service for their patients' convenience should not be unfairly penalized. This proposal appears to be directly opposed to CMS desire to focus more on preventative care as these diagnostic tests enable the early detection of potentially serious conditions.

SCAI strongly opposes the application of the MPPR to the technical component for diagnostic cardiovascular and ophthalmology diagnostic services when these services are furnished by the same physician/physician group to the same patient on the same day finding that these services are not commonly performed together and CMS' assumptions in regards to potential efficiencies in staff time and tasks are completely inaccurate resulting in a flawed methodology in the calculation of potential efficiencies for these services.

SCAI believes this proposal is not in the best interest of patients and has concern that the application of the MPPR to these diagnostic services will drive these services to the more expensive hospital outpatient setting, perhaps delaying early detection of potentially serious conditions.

Confidential Feedback Reports

CMS outlines its past, current, and anticipated future efforts to develop and disseminate confidential feedback to physicians. Physicians within the same specialty (e.g., cardiology) will be compared against each other on the cost and quality of their care to Medicare patients. Physicians will receive their 2014 reports based on 2013 data; however, there is no redistribution of funds. Instead, physicians will have the opportunity to educate themselves and make practice changes to improve future performance. The 2015 reports based on 2014 data will have the value-based modifier applied with redistribution of funds from low performers to high performers.

Comparison Groups

SCAI recommends that CMS stratify physicians by specialty (e.g., general cardiology) or sub-specialty (e.g., interventional cardiology) and the conditions they treat. In order to achieve comparison groups that are large enough to be statistically valid, CMS indicated that they will create groups of physician types that are so broad they do not result in "apple to apple" comparisons. As a result, physicians with very specialized expertise and complex patients may be identified as high-cost in comparison to other members of their specialty who treat less difficult conditions or patients. This is further complicated by Medicare's specialty designations (e.g., cardiology), which are inconsistent in their recognition of sub-specialized experience. SCAI recommends that sub-specialists are grouped together for quality and cost comparison, excluding specialists. An improved physician specialty and sub-specialty list could be applied consistently across many Medicare programs, including the value-based payment modifier, Physician Compare, and the Medicare Provider Enrollment, Chain and Ownership System (PECOS).

Cost Data

Cost data in the reports includes the average per capita cost of health care services for all Medicare beneficiaries whose care is attributed to the physician plus the per capita cost for patients with four conditions: chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and diabetes. SCAI is concerned that CMS has not improved its current risk adjuster, which is not precise enough to permit valid comparisons of per capita data at either the aggregate or condition-specific level. Consequently, we believe that there is a significant possibility that some physicians with high cost patients will be mislabeled as over-utilizers.

SCAI recommends that CMS stratify physicians by specialty or sub-specialty and the conditions they treat for report production and comparison of cost and quality amongst providers.

SCAI recommends that sub-specialists are grouped together, excluding specialists. When a more granular physician specialty and sub-specialty list is available, this list should be used across these Medicare programs, including the value-based payment modifier, Physician Compare, and the Medicare Provider Enrollment, Chain and Ownership System (PECOS).

SCAI is concerned that CMS has not improved its current risk adjuster for cost data and we believe that there is a significant possibility that some physicians with high cost patients will be unfairly mislabeled as over-utilizers.

Value-Based Payment Modifier

SCAI recommends limiting the value-based modifier to large integrated (or integrating) health systems where hospitals either employ the physicians or have ownership in the physician practices. This is consistent with the ACA's goal of encouraging systems-based care and with CMS' interest in developing and testing measures related to excess hospitalizations, readmissions, emergency room visits, and care coordination. It would align hospital and physician incentives and apply the adjustments to the physicians most equipped to finance and participate in the quality and efficiency improvement initiatives envisioned in the law. It is also more reasonable to impose detailed care coordination activities, such as follow-up visits and consultation reports, in hospital-based systems than it is in traditional Medicare where CMS has declined to cover care coordination activities and eliminated payments for consultations on grounds that reports from consultant physicians are not really necessary.

SCAI recommends limiting the value-based modifier to large integrated (or integrating) health systems where hospitals either employ the physicians or have ownership in the physician practices.

Conclusion

In closing, SCAI appreciates the opportunity to provide comment on issues contained in the "Payment Policies Under the Physician Fee Schedule for CY 2013; Proposed Rule; 77 Fed. Reg. 44,722 (July 30, 2012); CMS-1590-P "of high interest to the interventional cardiology community. If SCAI can be of any assistance as CMS continues to consider and review these issues, please do not hesitate to contact Ms. Dawn R. Hopkins, Director of Reimbursement & Regulatory Affairs at (800) 253-4636, ext. 510 or dhopkins@scai.org regarding any comments pertaining to the MPPR and Mr. Joel C. Harder, Director for Quality Initiatives and Clinical Documents at (800) 253-4636, ext. 701 or jharder@scai.org for all other matters.

Marilyn Tavenner
September 4, 2012
Page 7 of 7

Sincerely,

A handwritten signature in black ink, appearing to read "J. Jeffrey Marshall, MD, FSCAI". The signature is fluid and cursive, with the first name "J." and last name "Marshall" being the most prominent parts.

J. Jeffrey Marshall, MD, FSCAI
SCAI President, 2012-2013

CC: Ken Marsalek, CMS
Alexandra Mugge, CMS
Christine Estella, CMS
Gift Tee, CMS
Edith Hambrick, MD, JD, CMS
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