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Re: File Code-CMS-1590-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2013.

Dear Administrator Tavenner:

The American Society of Hematology (ASH) is pleased to offer comments on the proposed Medicare Physician Fee Schedule for 2013. ASH represents over 14,000 clinicians and scientists committed to the study and treatment of blood and blood-related diseases. ASH members include hematologists and hematologist/oncologists who regularly render services to Medicare beneficiaries.

We wish to offer comments on the proposed code for transitional care management services and the issues surrounding payment for the molecular pathology codes. In addition, there are two practice expense issues that were not specifically discussed in the rule, but are of particular interest to the Society.

Post-Discharge Transitional Care Management Services

CMS is proposing to create a G-code to describe the care management associated with the transition of a patient from care provided by a treating physician during a hospital stay or SNF stay to the care of the patient's primary physician in the community. The discharging physician would not be eligible to bill this new code nor would surgeons performing 10-day or 90-day global services. The new code will describe all non-face-to-face services related to the transitional care management (TCM) furnished to patients whose problems require moderate or high complexity medical decision making; the code must be billed within 30 days following the discharge date.

While we understand that the TCM code will be billed most often by primary care physicians, as described by CMS in the proposed rule, we believe that hematologists/oncologists and other medical subspecialists will meet the specified requirements and should be able to bill for this service. For example, a patient with leukemia or other blood disorder under the care of a hematologist may be admitted to a hospital for a surgical procedure or an unrelated medical condition.

For many of these patients the hematologist serves as the principle provider of medical care and is contacted by the discharging physician to coordinate care post-discharge. In these cases, the hematologist could bill the TCM. We are not sure what assumptions were made by CMS regarding the use of the new TCM code by physicians other than primary care physicians, general internists and nurse practitioners. In order to avoid any confusion as to the availability of this code to physicians other than primary care physicians or misunderstanding on the part of Medicare contractors, we ask CMS to make this clear in the final rule.

We understand that CMS will “budget neutralize” to offset the added cost for projected billings of the TCM code by making adjustments to the relative values for all services under the physician fee schedule. While ASH did not attempt to independently validate these estimates, we have seen an analysis submitted by the American Medical Association (AMA) to CMS, which suggests that the estimate of the number of TCM services that will be billed will be dramatically less than the 10 million per year projected by CMS in the proposed rule. We ask CMS to reexamine its estimates for the final rule in light of the AMA analysis.

In addition, the availability of the TCM code is expected to lead to improved post discharge care and a reduction in the rate of hospital readmissions. We ask that CMS utilize some of the projected savings from reduced hospital readmissions in determining the required budget neutrality adjustment under the physician fee schedule.

Molecular Pathology Code

ASH supports the inclusion of the molecular pathology services under the physician fee schedule as physicians are typically involved in the performance of most of the molecular pathology codes. We recommend that the professional work and practice expense inputs approved by the RUC be accepted by CMS. We see no advantage in having these services “carrier priced” except for perhaps an individual code(s) which is not defined in a reasonably consistent manner. Since hematologists are not the primary performer of molecular pathology testing, we are not able to provide answers to the specific questions posed by CMS in the proposed rule.

Anti-Coagulation Management

The practice expense values assigned to anti-coagulation codes, 99363, Anticoagulant management for a patient taking warfarin, initial 90 days and 99364, each subsequent 90 days of treatment were reduced to zero for 2013 in the proposed rule. We suspect this is an error because it is not discussed in the proposed rule and no rationale was provided for the change. Currently, the codes for anti-coagulation management are considered “bundled” by Medicare, but because these codes are recognized individually by non-Medicare payers, we ask CMS to reinstate the practice expense values, which seem to have been inadvertently eliminated.

Practice Expenses for Chemotherapy Codes

In the 2012 Physician Fee Schedule Final Rule, CMS adjusted the direct practice expense inputs for Code 96413 (Chemotherapy IV infusion, 1st hour) and Code 96416 (Chemotherapy Prolonged infusion, with pump) resulting in a significant reduction in the practice expense RVUs for these services. These codes were assigned interim values for 2012 and were open to comment. ASH submitted comments (restated below) that we ask be addressed in the final MPFS rule for 2013.

For Code 96413, CMS proposed a reduction of 3 minutes for “completing pre-service diagnostic and referral forms.” ASH believes that this time is justified and is consistent with time standards used by the Practice Expense Review Committee (PERC) of the RUC. It reflects the time for the oncology nurse to document the upcoming chemotherapy session based on the physician’s orders and to coordinate the service under the physician’s direction. Please note that this time was not claimed for Code 96416, which is billed with Code 96413 frequently. CMS also proposed to remove the time (3 minutes) to “coordinate pre-surgery services” from code 96413. This time is for the oncology nurse to assure that the planned infusion is consistent with the physician’s direction and that there is no change in the drugs to be infused, anti-emetics to be supplied and to follow post-treatment instructions. ASH asks that both of these time elements (6 minutes) be reinstated.

For Code 96416, CMS reduced the time to “assist physician to perform procedure” from 19 to 6 minutes on the grounds that it is conforming to the physician time. However, this is a misunderstanding of the activity that is being described. The element on the PE form reads “perform procedure or assist physician in performing procedure.” Thus, the time assigned should not be equivalent to the physician time of supervising the procedure since the actual procedure is done by the oncology nurse. We, therefore, ask that the full 19 minutes approved by the PERC for this task be accepted by CMS.

CMS also disallowed the 5 minutes assigned to monitoring the patient following the service/checking tubes, monitors, drains for code 96416. This time should be reinstated by CMS because the pump needs to be checked for correct operation after it has been fitted to the patient to assure that the infusion rates are appropriate.

Finally, the 4 minutes assigned to the task “review charts by chemo nurse regarding course of treatment and obtain chemotherapy related medical hx” was disallowed by CMS for code 96416 based on the stated rationale “CMS clinical review”. We ask that this time be reinstated since it is needed for the nurse to obtain the appropriate medical history and undertake chart review to ascertain the course of treatment and to confirm that there have been no previously undocumented toxicities.

Lastly, for Code 96416 ASH asks that the equipment time for the reclining chair be maintained at 100 minutes and not be reduced to 72 minutes since 100 minutes is consistent with the actual time the typical patient needs to be in the chair. At a minimum the time should be adjusted to a total of 94 minutes which represents the reinstatement of the 22 minutes of disallowed staff time (13+5+4) discussed above.

Physician Quality Reporting System (PQRS)

ASH was one of the first medical specialty societies to develop quality measures recognized by Medicare, allowing many hematologists/oncologists to participate in Physician Quality Reporting System (PQRS). In fact, ASH’s four hematology measures recently received full endorsement by the National Quality Forum and the Society appreciates CMS’s inclusion of the hematology measures in the PQRS program for the 2013 reporting year. It is important to recognize, however, that there are numerous sub-specialists within the practice of hematology/oncology where the four hematology measures would not be applicable and the lag time for approval of additional measures is significant. Consequently, we are deeply concerned that these ASH members could be penalized in 2015 because they do not have any measures on which to report in 2013. While we welcome CMS’s flexibility in the proposed rule to report on only one PQRS measure or measure group to assist physicians with compliance, the Society asks that

CMS include an exemption for those physicians that due to their subspecialization and patient population cannot report any Medicare approved PQRS measures.

Thank you for the opportunity to offer these comments. For additional information, please contact ASH Senior Director for Government Relations, Practice & Scientific Affairs Mila Becker at mbecker@hematology.org or 202.776.0544.

Sincerely,

A handwritten signature in black ink, appearing to read "Armand Keating". The signature is fluid and cursive, with the first name "Armand" and last name "Keating" clearly distinguishable.

Armand Keating, MD