



American Society of Clinical Oncology

**PRESIDENT**

George W. Sledge, Jr., MD

**IMMEDIATE PAST PRESIDENT**

Douglas W. Blayney, MD

**PRESIDENT-ELECT**

Michael P. Link, MD

**TREASURER**

Clifford Hudis, MD

**CHIEF EXECUTIVE OFFICER**

Allen S. Lichter, MD

**DIRECTORS**

James L. Abbruzzese, MD

Monica M. Bertagnolli, MD

Eduardo L. Cazap, MD, PhD

Susan L. Cohn, MD

Bruce E. Johnson, MD

Robert M. Langdon, Jr., MD

Lori J. Pierce, MD

Lynn M. Schuchter, MD

Frances A. Shepherd, MD

Sandra M. Swain, MD

Everett E. Vokes, MD

Julie M. Vose, MD

Peter P. Yu, MD

Robin T. Zon, MD

August 24, 2010

Donald Berwick, M.D.  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G, Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**RE: CMS-1503-P – Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011**

Dear Administrator Berwick:

I am pleased to submit these comments on behalf of the American Society of Clinical Oncology (ASCO) in response to the recent notice of proposed rule making regarding the Medicare Physician Fee Schedule (MPFS) for Calendar Year (CY) 2011 (75 Federal Register 40040, July 13, 2010).

ASCO is the national organization representing over 28,000 physicians and other healthcare professionals specializing in cancer treatment, diagnosis and prevention. ASCO members also are dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidenced-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans, including Medicare beneficiaries. We appreciate the opportunity to comment on the policies that CMS is proposing for 2011.

ASCO provides the following recommendations regarding the proposed rule:

**A. MEI.** CMS should implement in full the methodology described within the proposed rule to revise and rebase the Medicare Economic Index (MEI) as a means to improve the fairness and adequacy of the payment levels assigned to Medicare's physician fee schedule.

**B. Consultation Codes.** CMS should reverse its current policy and resume payment for consultation codes under Medicare. The decision by CMS to end reporting and reimbursement for consultation codes for CY 2010 has resulted in an inequitable situation for oncologists and other sub-specialists who are needed to consult on patients with complex medical histories on a frequent basis. There are significant concerns that this change in policy is adversely impacting access to care.

- C. PQRI and QOPI.** CMS should finalize its proposal to promote the use of registries for reporting data to the PQRI, and we urge CMS to work closely with ASCO to integrate the Quality Oncology Practice Initiative (QOPI) within the PQRI and other aspects of the Medicare program. QOPI is a national, data-driven quality improvement program with over 600 registered community-based oncology practices throughout the United States.
- D. Oncology Performance Measures and QOPI.** CMS should expedite efforts to address the lack of meaningful performance measures that reflect the day-to-day treatment of cancer patients, and we urge CMS to work with ASCO and other relevant stakeholders to promote adoption of the QOPI performance measures, which are evidence based, peer developed, and well accepted in the oncology community.
- E. Safeguards on Implementation of PQRI.** CMS should exercise caution in posting comparative information on physician practices and imposing penalties on physician practices under the PQRI. In addition, CMS should ensure that physicians have meaningful opportunities to review and appeal information prior to public reporting.
- F. In-Office Ancillary Exception.** CMS should protect patient safety and reduce unnecessary administrative burdens on physician practices by clarifying the requirements and taking responsibility for generating the information on alternative providers that would be required to meet the in-office ancillary exception under the proposed rule.
- G. Excess Drug within Packaging.** CMS should revise the language used to describe the proposed regulatory safeguards regarding the use of any extra amounts of prescription drugs provided within standard packaging to eliminate ambiguity and promote clear understanding within the provider community.
- H. Recouping Drug Costs and AMP.** CMS should ensure that implementation of the price substitution authority for prescription drugs based on average manufacturer price (AMP) does not expand and exacerbate ongoing concerns regarding the ability of oncology practices to recoup the actual acquisition cost of oncology drugs. CMS should delay implementation of any price substitutions until the potential adverse impacts on access to oncology drugs in the physician office setting are evaluated and until the recent changes to AMP are fully implemented and understood.
- I. Flawed PPIS Data.** CMS should reverse its policy to phase in the use of data from the American Medical Association's Physician Practice Information Survey (AMA PPIS) to set the practice expense relative value units for physician services. The small sample sizes and lack of precision in the AMA PPIS data have likely overstated the expenses for other specialties, exacerbating longstanding problems that oncology practices face in recouping fair and adequate reimbursement for expenses incurred in providing patient care.
- J. eRxing.** CMS should revise the proposal to use 2011 as the reporting period for the electronic prescribing incentive program for the penalties calculated for both 2012 and 2013.

As with the proposed implementation of incentive payments, such data should not be reused for multiple years, and penalties should be based only on contemporaneous data.

- K. MPPR.** ASCO objects to the current MPPR policy and considers it yet another mechanism by which CMS has inappropriately cut payments for services provided by oncologists. ASCO is further concerned by the proposal to expand the MPPR across families of codes and does not believe CMS' justification for doing so is reasonable or sufficient. ASCO encourages CMS to withdraw this proposed policy.

These recommendations are discussed in greater detail below.

- A. MEI. CMS should implement in full the methodology described within the proposed rule to revise and rebase the Medicare Economic Index (MEI) as a means to improve the fairness and adequacy of the payment levels assigned to Medicare's physician fee schedule.**

ASCO supports the efforts by CMS to update the methodology used to determine payment levels under the Medicare physician fee schedule by rebasing and revising the MEI. The changes proposed for the MIE by CMS represent some preliminary steps to improve the adequacy of payments under the Medicare physician fee schedule by better reflecting the expenses incurred by physician practices. To this end, we urge CMS to implement in full the changes described by CMS in the proposed rule.

Under the rebasing of the MEI in the proposed rule, the distribution of weights assigned to each MEI category, including physician work, practice expenses (PEs) and professional liability insurance (PLI), would shift. We have examined this proposal in detail, and we support the decision by CMS to adjust the relative value units upward for PEs and PLI while making a corresponding adjustment to the conversion factor without modifying the relative value units for work assigned to each CPT code.

Although ASCO urges CMS to finalize the proposed revisions and rebasing of the MEI, significant additional efforts are required to ensure that payment levels under Medicare Part B are adequate to permit oncology practices to recoup the significant expenses incurred in providing Medicare beneficiaries with access to chemotherapy and other key aspects of modern cancer care. We urge CMS to collaborate with ASCO in addressing these important issues in the near future.

- B. Consultation Codes. CMS should reverse its current policy and resume payment for consultation codes under Medicare. The decision by CMS to end reporting and reimbursement for consultation codes for CY 2010 has resulted in an inequitable situation for oncologists and other sub-specialists who are needed to consult on patients with complex medical histories on a frequent basis. There are significant concerns that this change in policy is adversely impacting access to care.**

ASCO continues to oppose the elimination of payment through the consultation codes under Medicare, and we urge CMS to reinstate separate reporting and reimbursement for consultation services under the Medicare physician fee schedule. These services benefit patients with cancer and other serious conditions by allowing additional, in-depth expert review of patients with complex and/or rare diseases, promoting enhanced communication among the physicians providing care for these patients.

In the notice of proposed rule making, CMS expresses an interest in comments on its prior decision to eliminate “the reporting of all CPT consultation codes in order to allow for correct and consistent coding and appropriate payment for evaluation and management services under the PFS.” Consistent with our position when CMS first proposed this change, ASCO opposes the elimination of the reporting and reimbursement of the consultation codes, and we strongly disagree with CMS’ rationale. In fact, this change in policy has resulted in less accurate payments for important physician services and is likely leading to greater confusion.

Although ASCO agrees that there was confusion in the past regarding when to bill appropriately for a consultation as opposed to a new patient visit, the proper solution is for CMS to provide increased education and clarification of these matters – not to eliminate the set of CPT codes critical to reporting work provided by oncologists in the form of consultation services. Confusion is not an appropriate rationale for eliminating consultation codes altogether. Instead, CMS should reinstate the reporting and reimbursement of the consultation codes and clarify the appropriate use of these codes.

Further, the associated redistribution of value from the eliminated consultation codes to new and established patient E&M services is inequitable and unfair. CMS never provided a meaningful rationale for this redistribution. We estimate that during CY 2010 oncologists are experiencing decreases in payments under Medicare for these services in excess of 25 percent as a result of this change.

When used appropriately, consultations represent a clinically effective and cost effective approach to provide needed expertise to the care of patients with cancer and other life-threatening diseases. Consultations can help ensure that patients receive care that is consistent with the scientific literature and the applicable clinical guidelines, helping to avoid complications and adverse events. However, the new policy creates a perverse financial incentive for physicians to avoid collaborating and communicating in the care of patients with complex medical disorders. The policy to eliminate payment for the consultation codes should be reversed.

ASCO strongly encourages CMS to reinstate reimbursement of consultation codes and is committed to work with the agency to educate the provider community on the appropriate use of these codes.

**C. PQRI and QOPI. CMS should finalize its proposal to promote the use of registries for reporting data to the PQRI, and we urge CMS to work closely with ASCO to**

**integrate the Quality Oncology Practice Initiative (QOPI) within the PQRI and other aspects of the Medicare program. QOPI is a national, data-driven quality improvement program with over 600 registered community-based oncology practices throughout the United States.**

We are pleased that CMS continues to take steps towards using a registry-based reporting system for PQRI measures as the primary mechanism for collecting PQRI data. As stated in the rule, we agree that reporting quality measures through a registry allows for timely reporting and provides a useful mechanism for feedback to physicians.

We believe that a properly designed clinical registry can provide the ideal platform for addressing a wide range of issues in the modern oncology practice setting, including quality improvement, collection of scientific data and communication with Medicare and other health insurance programs. There is no question that the oncology community faces particular challenges in pursuing these objectives at the same time that the administrative burdens on oncology practices are growing exponentially. Meeting these challenges is going to be critical in determining the participation level within the cancer community under the Physician Quality Reporting Initiative (PQRI), comparative effectiveness research efforts and other important initiatives.

ASCO is uniquely positioned to offer its resources as a means for promoting participation by oncology practices throughout the United States under the PQRI and other Medicare initiatives. In particular, ASCO has developed and continues to operate the Quality Oncology Practice Initiative (QOPI), which is a national, data-driven quality improvement program with over 600 registered community-based oncology practices throughout the United States. As such, QOPI is the obvious vehicle for promoting the use of quality improvement programs in the oncology community, including participation in PQRI.

The wide acceptance of QOPI throughout the oncology community draws on ASCO's thorough understanding of the scientific and operational aspects of providing oncology care. For example, ASCO plays a leading role in the development of consensus clinical guidelines in the area of oncology. ASCO also publishes the *Journal of Clinical Oncology*, which is a well established peer-reviewed journal for disseminating significant clinical oncology research findings. ASCO publishes the *Journal of Oncology Practice*, which focuses on issues regarding clinical and administrative management for practicing oncologists, and ASCO also provides a wealth of educational resources to the oncology community through ASCO University and to the public through Cancer.Net.

We urge CMS to work with ASCO to help foster active participation by community-based oncology practices where over 80 percent of cancer treatment is delivered in the important work of CMS under the PQRI and related efforts to collect data and improve health care outcomes for Medicare beneficiaries with cancer. We would welcome the opportunity to provide CMS with access to our staff and volunteers who work on QOPI and other related ASCO initiatives.

**D. Oncology Performance Measures. CMS should expedite efforts to address the lack of meaningful performance measures that reflect the day-to-day treatment of cancer patients, and we urge CMS to work with ASCO and other relevant stakeholders to promote adoption of the QOPI performance measures, which are evidence based, peer developed, and well accepted in the oncology community.**

ASCO supports the inclusion of three performance measures within the proposed rule that ASCO has endorsed previously. These three measures include: 1) providing hormonal therapy to appropriate breast cancer patients (measure 71); providing chemotherapy to Stage III colon cancer patients (measure 72); and documenting cancer stages (measure 194). These are all useful and important components of the set of measures used under the PQRI.

Although there are now approximately one-dozen PQRI performance measures that are related to oncology (including two new proposed measures), these measures are completely inadequate in both scope and substance to reflect and promote high quality care in the oncology practice setting. For example, some of the existing measures are more meaningful in settings of care that are more directly involved in the initial detection of cancer than the traditional oncology practice, which typically sees patients after the diagnosis of cancer is already suspected. Other measures are limited in their applicability. For example, patients may have an office visit for chemotherapy treatment without the physician providing an additional service, such as an evaluation and management service. However, several existing cancer related measures cannot be reported unless chemotherapy is administered on the same day.

ASCO has developed scores of consensus-based measures that are specific to the operation of modern oncology practices. These measures are based on the leading scientific developments and clinical guidelines in oncology, and are studied and validated through field testing in oncology practices throughout the United States. For the fall of 2010, QOPI is collecting data from hundreds of participating oncology practices regarding 84 clinically-relevant performance measures.

We would welcome the opportunity to meet with CMS staff regarding these important issues. In the interim, a summary of the current measures used by QOPI is posted on the following web page: <http://qopi.asco.org/Methodology>.

**E. Safeguards on Implementation of PQRI. CMS should exercise caution in posting comparative information on physician practices and imposing penalties on physician practices under the PQRI. In addition, CMS should ensure that physicians have meaningful opportunities to review and appeal information prior to public reporting.**

ASCO urges CMS to exercise caution in the development and implementation of the PQRI and related activities. For example, CMS is required to develop the Physician Compare Internet website by January 1, 2011 under the recent health care legislation. This website will be used to

post information about physicians who are enrolled in the PQRI program as well as to serve as a repository for information on the quality measures reported by enrolled physicians.

Significant concerns exist regarding the potential for misrepresentation and misunderstanding of posted data, and we believe that physicians participating in the PQRI program should have the opportunity to review and comment upon any data before it is posted on the website.

Given the difficulty oncologists face in using the current PQRI measures, we also are concerned about the penalties that will be established beginning in 2015 for failure to report quality measures satisfactorily. We request clarification from CMS on how these penalties will be applied and under what circumstances.

We are pleased that CMS is taking steps to implement an informal appeals process for those providers who submit data but, according to CMS' initial review, do not "satisfactorily submit" data for the purpose of qualifying for a PQRI incentive payment. Additionally, we strongly support the provisions in the health care legislation that require CMS to provide eligible providers with timely feedback on their performance with respect to satisfactorily submitting data on quality measures. We urge CMS to work with ASCO and other stakeholders to address this important safeguard, and we request that CMS provide additional details on how this "timely feedback" will be communicated.

In addition, we are pleased that Congress provided for an additional incentive payment of 0.5 percent for physicians who satisfactorily report quality measures in years 2011 to 2014. However, we request clarification on the requirements to receive the additional 0.5 percent incentive payment.

**F. In-Office Ancillary Exception. CMS should protect patient safety and reduce unnecessary administrative burdens on physician practices by clarifying the requirements and taking responsibility for generating the information on alternative providers that would be required to meet the in-office ancillary exception under the proposed rule.**

One of the growing threats to the viability of oncology practices is the increase in administrative burdens placed on these practices. Viewed individually, the administrative burdens may seem modest. However, when viewed in the aggregate, these requirements divert significant resources away from patient care and promote increases in health care costs. Such administrative burdens are needlessly accentuated when physician practices are required to perform tasks that could be performed more efficiently by CMS or when the guidance surrounding these requirements is ambiguous or incomplete. Our comments on the in-office ancillary exception focus on these concerns rather than the relative merits of the underlying requirement.

Within the preamble to the recent notice, CMS outlines its proposal to implement a provision from the health care reform legislation that requires physicians who refer and also provide certain imaging services to inform their patients in writing that the beneficiary may also receive

the same service from another provider. Specifically, this statutory requirement pertains to the in-office ancillary services exception to the prohibition on physician self-referrals and is limited to the provision of magnetic resonance imaging (MRI), computed tomography (CT) and positron emission tomography (PET) services.

ASCO urges CMS to revise this proposed rule to eliminate the unnecessary burdens on physician practices. CMS' proposal would require physician offices to generate and provide a written list of at least 10 other suppliers who provide the same services within a 25 mile radius (or a list of all other suppliers if fewer than 10 exist within a 25 mile radius). This requirement is excessive, placing an unnecessary administrative burden on the referring physician.

If the requirement is finalized, the provision of this written list to the patient runs a significant risk of being viewed as an endorsement of the providers on the list by the referring physician. However, referring physicians are not responsible for any aspect of the quality of care (or degree of compliance with Medicare regulations and guidelines) provided by other suppliers who may appear on such a list. We urge CMS to clarify that any referring physician subject to this requirement is permitted to clearly indicate on the same form that this disclosure notification is not an endorsement, guarantee or indication of support for the listed suppliers.

Even with such a disclaimer notice, patients still may perceive the list of suppliers as an implicit recommendation. Many patients may inappropriately infer that all suppliers for MRI, CT and PET services included on the written notice have been vetted and approved by their treating physician, when in fact this would not be the case. We are concerned that this will create confusion for vulnerable Medicare beneficiaries and their families rather than serve as a resource for patients.

As outlined in the proposed rule, CMS states that the list of suppliers must contain each supplier's name, address, phone number and distance from the referring physician's office location. Although obtaining this information might seem reasonable at first blush, the burden associated with maintaining a current list and up-to-date contact information is not reasonable, and the administrative burden may vary between urban and rural settings. ASCO requests clarification from CMS on the frequency with which the treating physician must review and update this list of suppliers if the requirement is finalized. However, we also note that requiring updates to this list runs counter to CMS' statement in the proposed rule that the physician or group practice would incur only a one-time cost associated with developing the disclosure notice.

Additionally, ASCO disagrees with CMS's estimate that it would only require one hour to create and maintain this notice – signed by the patient – as part of the patient's medical record. Notwithstanding administrative time required to develop this list, CMS' one hour estimate gives no regard to the time associated with patient follow-up that will be necessary to ensure the notification has been signed and returned. This CMS estimate also ignores medical record chart review that physician offices will need to incorporate into their administrative processes to ensure compliance with this requirement. ASCO believes CMS significantly underestimated the administrative burden associated with this provision.

Further, ASCO recommends that CMS set different radii requirements for urban versus rural areas. CMS' proposal to require at least 10 other suppliers who provide the service located within a 25 mile radius of the physician's office location may be excessively burdensome in different localities. For example, in an urban setting such as Midtown Manhattan, there could be many more than 10 providers within a 25 mile setting, placing the burden on the treating physician to make a decision regarding which providers to include in the written notification. As the written list in no way implies endorsement by the treating physician, alternative suppliers included become a matter of chance and circumstance (not informed guidance for the beneficiary).

Conversely, in a rural setting with fewer than 10 other suppliers within a 25 mile radius, the burden of identifying and providing all suppliers of imaging services is excessive. ASCO does, however, agree with CMS' qualification that provision of the written list will not be required if no other suppliers provide the services for which the beneficiary is referred within a 25 mile radius.

We urge CMS to develop a mechanism for generating appropriate lists to satisfy this requirement, perhaps on the CMS website. Such functions are commonplace on commercial websites, and this would significantly diminish the burden on physician offices struggling to comply in full with CMS requirements. In addition, we recommend that CMS provide greater clarity about the various aspects of ambiguity regarding this requirement discussed above, and we urge CMS to refrain from extending this requirement beyond the scope of the three types of imaging services listed within the statute.

**G. Excess Drug within Packaging. CMS should revise the language used to describe the proposed regulatory safeguards regarding the use of any extra amounts of prescription drugs provided within standard packaging to eliminate ambiguity and promote clear understanding within the provider community.**

CMS proposes to update its regulations to clarify that payment for "free product, or product in excess of the amount reflected on the FDA-approved label, will not be made under Medicare." Although we believe we understand the intent of this statement, this sentence is ambiguous and will be subject to misinterpretation. We recommend that CMS provide greater clarification to this instruction. The issue could be remedied by rewording the sentence referenced above or providing additional descriptive language.

Specifically, the regulatory guidance should be clarified to reflect that this statement refers to how the product is supplied (i.e., in which dosage forms and strengths it is supplied by the manufacturer, as listed in the "Dosage Forms and Strengths" section of FDA-approved drug package inserts). Further, CMS should clarify that this does not apply to the dose of the drug a patient is permitted to receive under Medicare coverage guidelines or clinical guidelines. In other words, if multiple vials are used for one dose for one patient, the statement referenced

above from the notice of proposed rule making does not mean that payment by Medicare would be limited only to amounts listed in the “how supplied” portion of the FDA-approved label.

**H. Recouping Drug Costs and AMP. CMS should ensure that implementation of the price substitution authority for prescription drugs based on average manufacturer price (AMP) does not expand and exacerbate ongoing concerns regarding the ability of oncology practices to recoup the actual acquisition cost of oncology drugs. CMS should delay implementation of any price substitutions until the potential adverse impacts on access to oncology drugs in the physician office setting are evaluated and until the recent changes to AMP are fully implemented and understood.**

ASCO supports the agency’s decision to continue to proceed carefully in implementing any policy to substitute an alternative to 106 percent of the Average Sales Price (ASP) for reimbursement of prescription drugs administered in the physician office setting under Medicare Part B. This includes the statutory authority that exists to substitute a payment level based on 103 percent of the Average Manufacturer Price (AMP) for a prescription drug if a threshold set by CMS is exceeded.

The fact remains that many physician practices are unable to purchase a number of oncology drugs at 106 percent of ASP, so any policy that further lowers the payment levels risks triggering further exacerbations to the access issues faced by Medicare beneficiaries in finding a chemotherapy provider.

As a result, ASCO urges CMS to ensure that implementation of the price substitution authority does not expand or exacerbate the situations where oncology practices would be unable to recoup the cost of a drug based on the acquisition cost and the Medicare payment level. In addition, we urge CMS to delay implementation of any price substitutions until recent changes to AMP are fully implemented and the potential impacts on access to cancer drugs can be studied and understood. We also urge CMS to monitor market prices and avoid imposing a price substitution in situations where oncology physician practices are likely to be “under water” for a particular drug or biological.

**I. Flawed PPIS Data. CMS should reverse its policy to phase in the use of data from the American Medical Association’s Physician Practice Information Survey (AMA PPIS) to set the practice expense relative value units for physician services. The small sample sizes and lack of precision in the AMA PPIS data have likely overstated the expenses for other specialties, exacerbating longstanding problems that oncology practices face in recouping fair and adequate reimbursement for expenses incurred in providing patient care.**

We strongly object to the use of data from the American Medical Association’s Physician Practice Information Survey (AMA PPIS) that CMS began using in CY 2010 to set the PE relative value units under Medicare Part B. Although ASCO recognizes and appreciates the use of the Gallup data for medical oncologists in lieu of the AMA PPIS data for setting PE relative

values, the use of the AMA PPIS data for the majority of other specialties distorts the relative value system for oncologists.

The small sample sizes and lack of precision in the AMA PPIS data have likely overstated the expenses for other specialties, exacerbating longstanding problems that oncology practices face in recouping fair and adequate reimbursement for expenses incurred in providing patient care. Although CMS has established precision criteria for the use of similar data, CMS has asserted that the application of precision criteria to the AMA PPIS is not necessary because the AMA PPIS was a “contemporaneous, consistently collected, and comprehensive multispecialty survey” (74 Federal Register at 33531). This rationale from CMS is nonsensical and we strongly disagree.

Simply collecting data on multiple specialties at the same time does not ensure the validity of the data if the sample sizes for the individual specialties are too small. Although the precision of the PEs per hour for “all physicians” generated by the AMA PPIS may provide a reliable result, it is the PEs per hour for each individual specialty that are critical to assigning relative values to particular codes. Similar criticisms have been voiced by a number of other national medical specialty societies. Although CMS did release findings from follow-up analysis conducted by its contractor in response to those comments, the AMA PPIS data remain fundamentally flawed.

Due to the fundamental statistical shortcomings of the data from the AMA PPIS, the data should not be used to establish PE values. We urge CMS to reverse its policy initiated in CY 2010 to use the AMA PPIS data to establish PE relative values for any specialties under the Medicare physician fee schedule.

- J. eRxing. CMS should revise the proposal to use 2011 as the reporting period for the electronic prescribing incentive program for the penalties calculated for both 2012 and 2013. As with the proposed implementation of incentive payments, such data should not be reused for multiple years, and penalties should be based only on contemporaneous data.**

There are important aspects of the electronic prescribing (eRxing) initiative that require revision prior to implementation. In particular, ASCO strongly recommends that CMS revise its proposal to use CY 2011 as the reporting period for penalties in both CYs 2012 and 2013. As proposed, the penalties attributed to a single year would be excessive, and the proposal fails to achieve the overarching incentive of continuing to encourage providers to participate in the eRxing initiative. As with the incentive payments, penalties should be based only on contemporaneous data.

- K. MPPR. ASCO objects to the current MPPR policy and considers it yet another mechanism by which CMS has inappropriately cut payments for services provided by oncologists. ASCO is further concerned by the proposal to expand the MPPR across families of codes and does not believe CMS’ justification for doing so is reasonable or sufficient. ASCO encourages CMS to withdraw this proposed policy.**

ASCO opposes the CMS proposal to expand the current imaging MPPR policy. In this notice of proposed rule making, CMS outlines its intent to apply the MPPR regardless of imaging family and to no longer limit the policy to multiple imaging services of contiguous body areas (i.e., the policy would apply to multiple imaging services furnished within the same family or across families of codes). We believe it is inappropriate and unnecessary to expand the imaging MPPR policy beyond the mandate established by Congress under the recent health care reform legislation.

Currently, the imaging MPPR applies to the technical component (TC) of CT/CTA, MR/MRA and ultrasound services within 11 families of codes based on imaging modality and body region. Full payment is made for the TC of the highest-paid procedure and payment is reduced by 25 percent of the TC for each additional procedure when multiple imaging services within the same family are performed together. Effective July 1, 2010, the legislation increased the MPPR on the TC of imaging services from 25 to 50 percent. Analysis conducted for ASCO suggests that oncology specialties bill approximately 5 percent of all claims subject to the current imaging MPPR policy with estimates indicating almost \$42 million (between 2006-2009) in reduced payments to oncologists as a result<sup>1</sup>—notwithstanding additional reductions anticipated for the second half of 2010 and beyond.

ASCO urges CMS to withdraw this proposed policy.

\* \* \* \* \*

Thank you for the opportunity to submit comments on this proposed rule. If you have any questions or would like to request assistance from ASCO on any issues involving the Medicare and Medicaid programs, please contact Karen Hagerty, M.D. at 571.483.1614 or [Karen.Hagerty@asco.org](mailto:Karen.Hagerty@asco.org).

Sincerely,



George W. Sledge, Jr., MD  
ASCO President

---

<sup>1</sup> 5% Carrier Standard Analytic File. Oncology specialties: hematology oncology, medical oncology, gynecology oncology, surgical oncology.