

**2005-2006 BOARD**

**PRESIDENT**

Sandra J. Horning, MD

**PRESIDENT-ELECT**

Gabriel N. Hortobagyi, MD

**IMMEDIATE PAST PRESIDENT**

David H. Johnson, MD

**SECRETARY/TREASURER**

David R. Gandara, MD

**EXECUTIVE VICE PRESIDENT**

**AND CHIEF EXECUTIVE OFFICER**

Charles M. Balch, MD

**DIRECTORS**

Jose Baselga, MD

Joseph DiBenedetto, Jr., MD

S. Gail Eckhardt, MD

Alexander M. Eggermont, MD, PhD

Peter D. Eisenberg, MD

Patricia A. Ganz, MD

Lee J. Helman, MD

Barbara L. McAneny, MD

Bruce D. Minsky, MD

Hyman B. Muss, MD

Michael C. Perry, MD

Nagahiro Saijo, MD, PhD

George W. Sledge, Jr., MD

Jamie H. Von Roenn, MD

2006 Annual Meeting

June 2-June 6, 2006

Atlanta, Georgia

For more information

about ASCO Meetings

Phone: (703) 631-6200

Fax: (703) 818-6425

Website: [www.asco.org](http://www.asco.org)

Via Hand Delivery

September 29, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Re: CMS-1502-P: Revisions to the Payment Policies Under the  
Physician Fee Schedule for Calendar Year 2006

These comments are submitted by the American Society of Clinical Oncology (ASCO) in response to the proposed changes in the Medicare physician fee schedule for 2006, as published in the Federal Register on August 8, 2005. ASCO is the national organization representing physicians who specialize in the treatment of patients with cancer.

As outlined below, ASCO has several concerns with the proposed changes:

- A final decision on the proposed revision in the methodology for determining practice expense relative values should be deferred one year until information is available on how the proposal will affect drug administration services.
- Any revision in the methodology for direct costs should be accompanied by a revision in the methodology for allocating indirect costs. Both The Lewin Group and the Government Accountability Office have found that the current methodology for indirect costs is biased against services that lack a physician work component.
- There is no empirical support for the proposal to reduce payments for multiple imaging procedures by an arbitrary 50%. Any reduction should be based on sound data demonstrating the amount of work and supplies that are actually avoided when there are multiple imaging procedures.
- The current demonstration project on chemotherapy services and the associated payment should be continued in 2006 in the current or modified form to ensure the continued broad availability of chemotherapy services.



## **PRACTICE EXPENSE RELATIVE VALUES**

CMS is proposing to revise its method for determining the relative values for practice expenses assigned to each service. Currently, the fee schedule is based on a “top down” methodology, which starts with the practice expenses per hour of physician work for each specialty as determined in the American Medical Association’s Socioeconomic Monitoring System survey or in supplemental surveys, such as the survey conducted for ASCO by The Gallup Organization.

CMS is proposing to change the methodology to be a “bottom up” methodology for direct costs (clinical staff, supplies, equipment) while retaining use of the top down approach for indirect costs. Direct costs would be determined by using the estimated costs for clinical staff, supplies, and equipment that have been made by the AMA’s Relative Value Update Committee or the previous Clinical Practice Expert Panels. The change would be phased in over a four-year period.

The practice expense relative value units for drug administration services in 2006 are not being changed under this proposal because CMS lacks utilization data for the new drug administration codes that were created for 2005. Therefore, the proposed revised method would not be implemented for drug administration services until 2007 after utilization data are available.

CMS is proposing to retain the current method for determining indirect costs under the practice expense methodology. The notice states that “we have no information that would indicate that the current indirect PE methodology is inaccurate.”

ASCO has two concerns with this proposal. First, there is no information in the notice about how the proposed change to a bottom up methodology would affect the payment amounts for drug administration services since those would not be changed until 2007. Proposing a significant change in the payment methodology without offering any guidance about how it will affect key services for our specialty does not afford us a reasonable opportunity to comment on the proposal. ASCO requests that consideration of the proposal be deferred until next year when complete information on all of the codes will be available.

Second, the methodology for dealing with indirect costs should be revised at the same time that the methodology for direct costs is changed. CMS’s own contractor, The Lewin Group, has said that the current methodology is biased against services that are furnished by nurses and other nonphysicians because it sets payment amounts based in significant part on how much physician work is involved. In its June 2001 report to CMS, Lewin stated:

“CMS’s top-down PE [practice expense] methodology includes a bias against TC [technical component] and other zero [physician] work services in the allocation of indirect costs to the procedure-code level. . . . CMS will have to address the issues of the allocation of indirect costs to zero work services in the top-down methodology before moving zero work services back into the originally proposed PE [practice expense] methodology.” (p. 17)



The Government Accountability Office (“GAO”) made the same point in an October 2001 report. The GAO stated:

“[T]he basic method for allocating indirect expenses for all services, which relies partly on physician work as the basis for allocation, does not adequately account for the indirect costs associated with nonphysician services. Because nonphysician services have no physician work associated with them, they are allocated a lower share of indirect expenses compared with services that are performed by physicians.” (p. 22)

The GAO recommended that CMS “change the allocation of indirect expenses so that all services are allocated the appropriate share of indirect expenses.” (p. 25)

There is ample evidence from these independent studies that the methodology for the indirect cost allocation needs reform. Services such as drug administration services that are furnished largely or entirely by nonphysician staff do not receive an adequate allocation of indirect costs under the current methodology, and this shortcoming should be rectified.

#### **PAYMENT REDUCTION FOR MULTIPLE DIAGNOSTIC IMAGING PROCEDURES**

CMS is proposing to reduce payments for diagnostic imaging procedures when more than one procedure in the same “family” of services is furnished to the same patient on the same day. The payment for the technical component of the second and additional procedures would be 50% of the normal payment amount. This reduction is proposed because CMS believes that some of the clinical staff activity, such as greeting the patient and providing education, is not repeated for each procedure. In addition, some supplies are not duplicated for each procedure. The payment for the professional component of the service would not be subject to the reduction.

ASCO opposes this proposal. While some of the clinical staff work for a procedure may not have to be repeated when there are multiple procedures in the same encounter, the proposal includes no basis for assuming that the duplicative work amounts to 50% of the value of the procedure. Instead, CMS has simply applied the 50% reduction used for payment of multiple surgical procedures. We believe that any reduction in payment for multiple imaging procedures should be supported by a study specific to imaging procedures demonstrating how much work and additional supplies are actually avoided when multiple procedures are performed. An arbitrary reduction of 50% should not be implemented in the absence of supporting data.

#### **CHEMOTHERAPY-RELATED DEMONSTRATION PROJECT**

Currently, CMS is conducting a demonstration project in which self-assessments on nausea/vomiting, pain, and fatigue are collected from patients receiving chemotherapy. Although the proposal briefly discusses the adverse financial impact on oncologists if the demonstration project terminates at the end of 2005, the notice does not otherwise deal with the demonstration.



ASCO applauds CMS for its initiative in developing and carrying out the current demonstration project. It is an important step toward gathering information on the quality of cancer care, and the associated payments have been vital to ensuring the continuing broad availability of chemotherapy services.

ASCO recognizes that CMS can extend the demonstration project outside the framework of the physician fee schedule. Whether CMS acts in the final fee schedule notice or independently, ASCO strongly urges CMS to continue the demonstration project in its current or a modified form. A demonstration project allows the collection of important information on the quality of cancer care, while at the same time supporting access to cancer care services.

Thank you for the opportunity to comment on the proposed fee schedule for 2006.

Sincerely,

A handwritten signature in black ink, appearing to read "John Cox", is written over a light blue circular stamp.

John Cox, DO  
Chair, Clinical Practice Committee