Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1600-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

August 22, 2013

REGARDING: Medicare Fee Schedule 2014 for Office Cement Augmentation

Dear Ms. Tavenner:

The Florida Society of Interventional Pain Physicians (FSIPP) is writing this letter to oppose the proposed caps and reductions in the office setting on vertebroplasty (CPT codes 22520-22522) and kyphoplasty (CPT codes 22523-22525). These outpatient percutaneous procedures use cement to stabilize vertebrae so that more invasive and costly inpatient surgeries are not required. The proposed reduction in reimbursement of 49.6% will eviscerate reimbursement to a point where costs will not be covered, effectively precluding the use of these procedures in the office setting, and costing the Medicare program more money in the long run.

There are few, if any, ASCs allowing kyphoplasty to be performed at their facilities. At the 2013 Medicare reimbursement rate of $3,289.61 to the ASC facility, the reimbursement does not cover the out-of-pocket cost of the procedure. Generally the cost of the cement augmentation equipment is approximately $3,500.00, not including facility expenses such as imaging, staff and plant overhead.

In 2011 the RUC meticulously measured the cost of providing the procedure in the office setting, counting equipment (needles, drapes, gauze pads, cement kits, balloons, etc.), staffing, imaging and plant consumption. In addition, most offices that provide these procedures are certified by their state Department of Health, which requires additional plant equipment and space, such as back-up generators, crash carts and more. A summary list of the requirements for certification by the Florida Department of Health is attached. (Attachment #1) These procedures require state of the art imaging equipment which includes a fluoroscope and table at an average cost of...
$200,000.00 and maintenance contracts for this equipment at $1000 per month. Staffing requirements include a CRNA or NP sedation monitor usually reimbursed at $60 to $100 dollars per hour and a radiology technician at a rate of $28 dollars per hour. The patient must be monitored during their entire stay which averages about 3-4 hours. Other materials including contrast dye are very expensive, as previously stated, and are considered by the RUC reimbursement determination, which includes many other items.

The reimbursement for office kyphoplasty (CPT 22523) including the facility and professional component for the year 2013 is $8,010.38. The CMS proposal to cut this fee by 49.6% - bringing the reimbursement to $4039.10 - will not cover the cost of the procedure and shift all cement augmentation cases to the hospital setting. This shift will have unintended consequences and increase the burden of the beneficiary fund, in the long run. To date patients have benefited by the convenience of having these procedures in the office setting. Patients are relieved that they are not exposed to potential nosocomial infection. The physician is able to achieve a level of efficiency that cannot be achieved in the hospital setting. In the long run there is a benefit to the beneficiary fund as the patient is able to avoid ER visits and hospital stays.

Please consider the following:

• CMS should not implement automatic caps on payments to physicians under the MPFS based on Medicare rates in the hospital outpatient prospective payment system (HOPPS) or ambulatory surgical center (ASC) settings. Any future payment adjustments should be based on an open, careful review of cost-data, and the public should have an opportunity to review and comment on such data. If CMS is proposing to limit the non-facility (office) practice expense (PE) RVUs so that the total office reimbursement would not exceed the HOPPS amount, CMS will not capture the full range of costs associated with performing these procedures. For instance, HOPPS reimbursement is subject to pricing anomalies based on a small number of hospitals performing a procedure or variations in hospital cost reporting practices.

• CMS should not ignore the cost data provided by the AMA RUC.

• If CMS nevertheless does decide to limit MPFS payments based on HOPPS or ASC rates, any such payment adjustments should be phased in over multiple years if the adjustment exceeds a specified threshold (5 percent or 10 percent).

We therefore recommend that CMS not implement automatic caps on payments to physicians under the MPFS based on other payment settings. Any payment adjustments should be based on an open, careful review of cost-data.

Additionally, considering recent data published in the United States and the United Kingdom cement augmentation is considered an efficacious and cost effective method of treating pathological compression fractures. Studies including 859,000 patients from the Medicare database have shown that these procedures decrease long term cost and add 2 to 7 years to life expectancy with improvement in quality of living. [1, 2, 3, 4] In 2000, literature published by Interventional Radiologists stated that the risk of not providing these procedures is greater than
the risk of providing them. In 2007 they supported this position statement in an extensive review. (5, 6)

Sincerely,

Deborah H. Tracy, MD
Deborah H. Tracy, MD
FSIPP, Immediate Past President

Sanford Silverman, MD
Sanford Silverman, MD
FSIPP, President
FSIPP, Board of Directors
FSIPP, Membership

Attachment #1. LEVEL II OFFICE PROCEDURES
Florida State Department of Health, Requirements for Level II Office Procedures


