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Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: **Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Physician-Owned Hospitals; Data Sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors; Appeals Process for Overpayments Associated With Submitted Data; Proposed Rule** [CMS-1613-P].

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate this opportunity to provide our comments regarding the Centers for Medicare & Medicaid Services' (CMS) 2015 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems (OPPS/ASC) Proposed Rule. As more procedures and treatments are available to patients in ASCs and hospital outpatient departments, and more physicians work in these settings, the OPPS/ASC policies take on increasing importance for physicians and for patients. Our comments focus on several main issues presented in the Proposed Rule. Our principal recommendations are set forth below, followed by more detailed comments. In addition, the AMA urges CMS to give considerable weight to the comments of individual medical specialty societies, recognizing their particular areas of expertise as well as the particular services their members provide.

- CMS appears to build upon its 2014 proposal to bundle many separately payable services into packages of services, in order to reduce incentives for providing unnecessary services in the hospital outpatient setting. The AMA continues to have considerable concerns about this approach. **We recommend that CMS proceed cautiously with its plans to bundle services and supplies while actively engaging with stakeholders and giving serious and thoughtful consideration to their input.**

- CMS plans to implement new policies shifting the publication of new and revised Current Procedural Terminology® (CPT®) codes to the proposed rule for each OPPS/ASC payment cycle, as it plans to do so for the Medicare Physician Fee Schedule (MPFS). The AMA supports this

important milestone in moving to greater transparency. **However, we echo the concerns we expressed with respect to the MPFS regarding the timing of adopting this proposal, and urge consideration of the alternative approach we have presented previously.**

- CMS proposes to continue a number of its policies—including updating the ASC conversion factor by a measure of inflation in the Consumer Price Index for Urban Consumers (CPI-U)—which further widen the gap between hospital outpatient department (HOPD) and ambulatory surgical center (ASC) rates. **We believe the current gap between HOPD and ASC rates is inequitable and we urge CMS to take immediate steps to reduce it.**

- CMS continues to modify its inpatient admission policy by proposing that physicians be required to certify hospital inpatient admissions only for long-stay cases and outlier cases. **We support CMS' effort to modify this policy to reduce the administrative burden on physicians; however, we strongly urge CMS to address the underlying issue—the unworkable two-midnight inpatient admissions policy.**

- **We strongly urge CMS to rescind the proposed use of a modifier to track services performed in provider-based billing departments.** We have serious concerns that it would be administratively burdensome and have a negative effect on office workflow.

I. Proposed Updates Affecting OPPS Payments

A. Establishment of Comprehensive Ambulatory Payment Classifications (APCs)

As CMS continues its initiative to pay physicians and providers through newly-created packages of items and services, we urge CMS to adopt a cautious approach in implementing this entirely new payment initiative. It is crucial that the agency adopt an ongoing receptiveness to provider input, and a willingness to readily and promptly revise this new payment methodology based on this input. This new payment methodology is a radical departure from longstanding Medicare policy and practice, and raises serious concerns for physicians, providers, and patients.

Device-Dependent APCs: First, with respect to Comprehensive APCs, all 39 of the current device-dependent APCs would now be reduced to 26 comprehensive APCs. This, in itself, is a significant reduction in previously separate and well-defined payment classifications. We are greatly concerned that this reduction could, by itself, negatively affect provider payment if the previously compensated items and services are no longer captured because payment categories have been collapsed. Additionally, under Comprehensive APCs, Medicare would make a lump sum payment for many items and services that typically have not been paid under the OPPS. More specifically, Comprehensive APCs would include all "adjunctive" services provided to support the delivery of a primary service. These would include diagnostic procedures and tests, laboratory tests, visits and evaluations performed in association with the primary procedure, uncoded services and supplies used during the primary procedure, therapy services, durable medical equipment, prosthetic and orthotic items and supplies, drugs, biologicals, and radiopharmaceuticals. Many of the items and services included in these categories have been paid under their own separate fee schedules. Also, procedures described by add-on codes that were previously assigned to device-dependent APCs and paid separately would now also be packaged in Comprehensive APCs.

Other Items and Services: Similarly, the Proposed Rule would implement packages for other items and services. CMS is proposing to package ancillary services when they are: 1) performed with another service; and 2) have a proposed geometric mean cost of less than or equal to $100. Prosthetic supplies, which are currently excluded from payment under the OPPS and are paid under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule, even when provided in the HOPD, would also be included in payment packages.

As CMS implements its new packaged payment policy, it is imperative that: 1) comprehensive APCs and other new payment packages are complete and accurate with respect to all of the CPT and HCPCS (Healthcare Common Procedure Coding System) codes included in those packages; 2) APCs be assigned to the correct clinical family; and 3) CMS' new packaged payment methodology does not reduce payments to physicians and other providers of outpatient services. Outpatient providers must be appropriately compensated for items and services that they furnish, and we do not support proposals that do not accurately account for the cost of providing an item or service, whether furnished under a fee schedule or under a packaged payment methodology. Accuracy and completeness, correct clinical family assignment, and adequate payment are essential to ensure that outpatient providers do not lose any flexibility regarding their ability to select supporting items and services that are medically appropriate for a given patient, and that providers are not financially incentivized or pressured to limit medically necessary items or services as a means to reduce costs to align with the payment package. **We therefore urge CMS to implement its new payment policy with extreme caution, remain receptive to provider input on an ongoing basis, and be readily amenable to revising its new packaged payment methodology based on that input. Finally, it is absolutely critical that CMS ensure that under no circumstances will the methodology have a negative effect on other means of Medicare reimbursement, e.g., the Medicare Physician Fee Schedule, that are not packaged-based.**

B. Complexity Adjustment

We strongly support CMS' proposed complexity adjustment to increase payments relating to Comprehensive APCs when a code combination of primary services represents a complex, costly form of the primary service. Under the Proposed Rule, the complexity adjustment would apply if: 1) there are at least 25 claims that report the same code combination (the frequency threshold); and 2) the comprehensive geometric mean cost of the code combination exceeds the comprehensive geometric cost of the lowest significant HCPCS code assigned to the comprehensive APC by more than two times (the cost threshold). Given, however, that comprehensive packaging is a radical departure from the manner in which CMS has paid OPPS claims, we urge that the cost threshold be lowered to 1.5 times the comprehensive geometric mean cost of the lowest significant HCPCS code assigned to the comprehensive APC, and we do not believe that the cost threshold should be raised until CMS has acquired sufficient experience with Comprehensive APCs to ensure that providers will not be subject to inadequate payments due to circumstances beyond their control.

We oppose CMS' proposal to limit the application of the complexity adjustment. No complexity adjustment is available if the primary service is already assigned to the highest cost APC within the comprehensive APC clinical family, as CMS does not propose to create new APCs with a geometric mean cost that is higher than the highest cost Comprehensive APC in a clinical family "just to accommodate potential complexity adjustments." We believe that it is ill-advised and premature to place an arbitrary cap on provider payments under a payment methodology that is such a significant departure from the historic way in which providers have been paid. Accordingly, we ask that CMS, in the course of

implementing its package payment policy, refrain from imposing arbitrary payment limits that ignore instances where the amount or intensity of items or services significantly exceeds that represented typically by a clinical family of packaged services.

C. Extended Assessment and Management Composite APCs (8002 and 8003)

CMS proposes to continue its policy of paying for all qualifying extended assessment and management (EAM) encounters through a single composite (APC 8009). We remain concerned that collapsing code levels is likely to penalize certain outpatient facilities, such as those that are attached to safety-net or teaching hospitals, which treat more complex patients and populations. This could lead to a decision by some facilities to admit borderline cases or deny treatment to beneficiaries who require complex care rather than absorbing losses in their outpatient departments due to the inability to bill a higher level EAM Composite. We urge CMS to monitor and readily accept provider feedback concerning the impact of this coding change to ensure that it does not create financial pressure or incentives to admit borderline cases, deny treatment, or otherwise negatively affect clinical decision making.

II. Proposed OPPS and ASC Treatment and Process for Solicitation of Public Comments for New and Revised CPT Codes

Currently, CMS allows the use of new and revised CPT Category I and III codes and Level II Healthcare Common Procedure Coding System (HCPCS) codes outside of the formal rulemaking process via the OPPS/ASC quarterly update Change Requests. CMS then makes interim APC and status indicator assignments, considers public comments through the annual rulemaking process, and finalizes assignment in the annual OPPS/ASC final rule. Payment rate is determined by assignment to a particular APC or status indicator (for items not paid separately).

For 2015, CMS plans to:

- Continue its established policy of recognizing Category I CPT vaccine codes for which Food and Drug Administration (FDA) approval is imminent and Category III CPT codes published each January for implementation in July through the OPPS quarterly update process;

- Incorporate Category III CPT codes, effective April 1 and July 1, 2014, in Addendum B of the 2015 OPPS/ASC final rule with comment period, consistent with longstanding practice; and

- Flag codes which take effect prior to a public comment period with a comment indicator "NI" in Addenda to the final rule with comment period, to indicate their payment status is interim, subject to public comment, and due for finalization in the final rule for the next calendar year's OPPS/ASC update.

Similar to the proposal in the Medicare Physician Fee Schedule, CMS reports that specialty societies and other stakeholders have urged the agency to publish new and revised CPT codes in the proposed rule prior to their effective date the following January—to allow public input into their APC and status indicator assignments at the initial stages. Consequently, CMS is now proposing to alter its process, as follows:

> For instance, we are proposing that, for new and revised CPT codes that we receive from the AMA CPT Editorial Panel too late for inclusion in the proposed rule for that year, we would

> delay adoption of the new and revised codes for that year, and instead, adopt coding policies and payment rates that conform, to the extent possible, to the policies and payment rates in place for the previous year. . .we are proposing to create HCPCS G-codes to describe the predecessor codes for any codes that were revised or deleted as part of the annual CPT coding changes. However, if certain CPT codes are revised in a manner that would not affect the cost of inputs (for example, a grammatical change to CPT code descriptors), we would use these revised codes and continue to assign those codes to their current APC.
>
> For new codes that describe wholly new services, as opposed to new or revised codes that describe services for which APC and status indicator assignments are already established, we would make every effort to work with the AMA CPT Editorial Panel to ensure that we received the codes in time to propose payment rates in the proposed rule. However, if we do not receive the code for a wholly new service in time to include proposed APC and status indicator assignments in the proposed rule for a year, we would need to establish interim APC and status indicator assignments for the initial year. We are proposing to establish the initial APC and status indicator assignments for new services as interim final assignments, and to follow our current process to solicit and respond to public comments and finalize the APC and status indicator assignments in the subsequent year.[1]

The AMA agrees that the timeline for reviewing new and revised CPT codes should align with the regulatory process, as we expressed many times in conversations and correspondence with CMS over the past year. We strongly urge CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 OPPS/ASC Payment Schedule. The development of new technology and new code bundles is already underway for the CPT 2016 code set. The cycle for the CPT 2016 code set began with code change applications for the May 2014 CPT Editorial Panel Meeting submitted by February 14, 2014, and will conclude on February 7, 2015. We believe that it would be highly inappropriate for CMS to implement this proposal in the November 1, 2014 Final Rule because the CPT Editorial Panel process for the 2016 cycle will already be nearly complete by that date. Requiring publication in a proposed rule next summer will delay their implementation in Medicare by another year. Those that have solicited new and/or revised CPT codes deserve timely consideration of their applications. They also deserve fair notice of the implementation date. If CMS were to announce a 2017 implementation date on November 1, 2014, it would provide appropriate notification to those submitting code change applications by the first CPT 2017 deadline of February 13, 2015.

We strongly urge CMS to adopt the AMA proposal for modifications in CPT/RUC workflow to accommodate publication in the Proposed Rule, while ensuring that new technology may be described and valued in an efficient and timely manner. The AMA proposal would eliminate the need for CMS to create G-codes, which essentially duplicate the CPT codes. We believe that the G-code proposal is entirely unworkable and should not be considered in finalizing the new process.

The CPT Editorial Panel and the AMA/Specialty Society Relative Value Scale/RVS Update Committee (RUC) each meet three times per year. Historically, the May CPT/October RUC meetings have been the first meetings of each coding cycle, followed by the October CPT/January RUC meetings, and finally the February CPT/April RUC meetings. Following the last set of meetings, CPT is finalized as a code set for

[1] 79 Fed. Reg. 40,978-9.

the next calendar year and the RUC submits recommendations to CMS for consideration and implementation in the Medicare Physician Fee Schedule. The RUC submits all recommendations no later than May 31 each year for consideration for the next payment schedule. As stated earlier, a CPT code originates with a code change application and the first applications of each cycle are due in February, followed by application deadlines in July and November. The current time required to generate a code/relative value ranges from 14 to 22 months from the time of application.

In order to accommodate the publication of proposed valuation of new, revised, and potentially misvalued services, CMS has proposed to require that all RUC recommendations be submitted by January 15 of each year. For 2016, this would mean that the May 2014 CPT/September RUC meeting would be the only opportunity for the medical community to offer description and recommended valuation of new technology and code bundles, since the RUC will not have the opportunity to consider codes from the October CPT Editorial Panel meeting until January 29, 2015. This is not just a matter of convenience or reluctance to reschedule a meeting, but rather it is due to the significant amount of survey work and data analyses that must be conducted prior to the RUC meeting—work that cannot begin until the code changes have been finalized.

In addition, CMS' proposal would extend the time required to generate a code/relative value to 22 to 30 months for each subsequent CPT code set cycle at a time when CMS, the CPT Editorial Panel and the RUC are being asked to reduce the amount of time needed to accommodate changes.

The AMA offered a detailed and reasonable proposal to expedite the CPT and RUC processes for new, revised, and potentially misvalued physicians' services.[2] This proposal would retain the current meeting infrastructure for both CPT and the RUC, while shifting the workflow to accommodate the review of commonly performed services to the May CPT/October RUC and October CPT/January RUC meetings. This would allow recommendations for the most significant MPFS changes to be reviewed, modified, and published by CMS in the proposed rule the following year. Under this proposal, the February CPT meeting would predominantly address editorial changes, clinical lab payment schedule services, and new technology services, with expected low volume. The April RUC meeting would replace the formerly lighter September RUC meeting agenda and would be utilized to review the low volume new technology services and discuss methodological and process issues. We believe that CMS should be able to publish consideration of the low volume new technology codes in the Final Rule as interim values, as these changes would have minimal impact on the other services in the MPFS. The AMA proposes to submit RUC recommendations to CMS within one month of each meeting (each November and February for new, revised, and potentially misvalued; and each May for low volume new technology).

The creation and adoption of temporary G-codes would unnecessarily add to the administrative burden of physicians and other providers who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. When this applies to large families of codes, the burden is even greater, as is the risk for coding errors. Moreover, this threatens to create a

[2]This proposal was initially discussed in the AMA letter to CMS dated June 3, 2014, and more recently in a joint letter to CMS dated August 12, 2014, on behalf of the AMA and 70 medical specialty societies representing physicians and non-physicians. The June 3, 2014 letter and related CPT-RUC schedule and timeline were enclosed as attachments to the RUC's August 22, 2014 comment letter on the 2015 MPFS Proposed Rule. The August 12, 2014 letter was submitted as a separate comment on the 2015 MPFS Proposed Rule, and is available online at: https://download.ama-assn.org/resources/doc/washington/x-pub/medicare-program-sign-on-letter-13aug2014.pdf.

situation of parallel but distinct coding between Medicare and private payers, as private payers are likely to implement new CPT codes as soon as they are published.

III. Proposed Nonrecurring Policy Changes: Collecting Data on Services Furnished in Off-Campus Provider-Based Departments

In order to understand trends in hospital acquisitions of physician practices, CMS proposes to create a HCPCS modifier to be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital. The modifier would be reported on both the CMS–1500 claim form for physicians' services and the UB–04 (CMS form 1450) for hospital outpatient claims.

We have serious concerns about the administrative burden that this proposal would impose on physician practices, and strongly urge CMS to rescind this proposal and instead engage with stakeholders to develop alternative methodologies for understanding trends in hospital acquisitions of physician practices. Requisite inclusion of a modifier for each code for services furnished in an off-campus provider-based hospital department would be a significant, unwarranted encumbrance on administrative workflow. There is not sufficient merit for CMS to impose this requirement simply to study hospital acquisitions of physician practices, a trend that is complex and unlikely to be fully understood by the collection of this data.

The AMA would be happy to work with CMS as it evaluates physician practice trends, and has a body of AMA-conducted research that CMS may find elucidative on this topic. The AMA has conducted extensive research on this topic, which CMS may find helpful.[3]

IV. Proposed Updates to the Ambulatory Surgical Center (ASC) Payment System

A. Proposed Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services

We strongly support the proposal to add ten new spine procedures to the ASC list of payable procedures for 2015. We also wish to echo the repeated pleas from the ASC industry and various physician specialties for more transparency in the designation of services that Medicare will pay for in an ASC. Experience with private sector patients clearly indicates that many of the CPT codes for which Medicare reimburses HOPDs but not ASCs could safely be performed in the ASC. CMS' exclusion of these codes from coverage in an ASC is therefore inexplicable. We also believe that CMS should expand its process for removing procedures from the inpatient-only list to more quickly reflect advancements in technology and clinical practice, and move more procedures to the ASC list, especially those with high-volume in the hospital outpatient department setting. We urge the agency's careful consideration of comments from individual specialties regarding additional procedures they believe should be covered in ASCs. Such additions would not only cut Medicare costs per service, but would also afford beneficiaries greater access, convenience, and options for care. We also endorse the ASC industry's call for a process by

[3] Kane, C.K., Emmons, D.W. "New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment." 2013. American Medical Association. https://download.ama-assn.org/resources/doc/health-policy/x-pub/prp-physician-practice-arrangements.pdf.

which CMS would indicate on a code-by-code basis why some services are excluded from payment in an ASC.

B. Calculation of the Proposed ASC Conversion Factor and the Proposed ASC Payment Rates

When CMS implemented the revised ASC payment system in 2008, the agency estimated significant growth in the volume and diversification of services within ASCs, due largely to a shift of services previously performed in the HOPD. Over the last six years, however, very little market share has migrated to ASCs, while hospitals are actually increasing their share of many services commonly performed in the ASC setting. New capacity is coming online primarily as the result of newly created or expanded hospital outpatient departments. A key reason for the slower-than-anticipated ASC growth can be found in inequitable Medicare policies that lead to ASC payment rates that are far below those for payment in an HOPD. Today hospital outpatient departments receive 81 percent more than ASCs for the same services. If CMS adopts its proposed payment updates, hospital outpatient departments would be paid 85 percent more than ASCs for the same procedures.

Because of this difference, both Medicare and its beneficiaries pay significantly less when services are provided in an ASC than when they are delivered in an HOPD. We believe that the Proposed Rule continues the policies that have produced this payment gap and discouraged shifting services to ASCs, while also potentially increasing the gap through some of its new bundling proposals. As we have previously noted, there is no valid rationale for using different wage indices in the calculation of rates for the ASCs and hospital outpatient departments. Nor is there any justification for subjecting the ASCs to lower annual payment updates year after year.

With regard to the annual update, CMS proposes to continue its policy of updating the ASC conversion factor by a measure of inflation in the CPI-U. There is broad agreement that the CPI-U: 1) measures inflation for a basket of consumer goods that are not typical of what ASCs purchase; and 2) is therefore flawed for the purposes of the ASC payment system. The hospital market basket, on the other hand, is an available proxy for ASC costs and is superior to the use of the CPI-U. The hospital market basket is also used to update the OPPS payment rates. Because the OPPS cost structure looks much like the cost structure of ASCs, if the hospital market basket is appropriate for updating OPPS payment rates, it is also appropriate for updating ASC payments. We therefore urge CMS to adopt the hospital market basket instead of the CPI-U to update ASC payment rates for inflation.

V. Proposed Changes to the Rural Provider and Hospital Ownership Exceptions to the Physician Self-Referral Law: Expansion Exception Process

The AMA supports CMS' proposal to expand the data sources that can be used to qualify for certain exceptions to the physician self-referral law, specifically the rural provider and whole hospital exceptions. This more flexible approach will ensure that providers who serve Medicaid managed care patients or lack relevant Medicaid cost report data will not be barred from qualifying despite meeting the appropriate statutory requirements. Given that access to supplemental data sources will vary based upon the entity seeking the exemption, we do not recommend that CMS prioritize or rank additional data sources. Instead, we agree with the broad approach taken in the Proposed Rule.

VI. Proposed Revision of the Requirements for Physician Certification of Hospital Inpatient Services Other Than Psychiatric Inpatient Services

The AMA supports CMS' effort to reduce the administrative burden on physicians currently in place via the two-midnight inpatient admissions policy. AMA policy supports the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services.

Since CMS' adoption of the two-midnight policy for inpatient admissions, CMS has released a litany of complicated guidance on physician documentation of inpatient admissions, including guidelines on physician certifications, which were augmented a number of times.[4] The requirement of both a physician certification and a physician order is overly burdensome for admitting physicians and has caused undue confusion. Should CMS adopt its proposal, however, we urge CMS to reiterate the requirements for physician orders of inpatient admissions under its revised regulations.

While we support CMS' effort to reduce the administrative burden caused by this policy, we are obliged to underscore that CMS' proposal does not solve the underlying problem: the two-midnight policy and its failure to address the multitude of issues surrounding inpatient admissions. CMS should repeal the two-midnight policy in its entirety and work with stakeholders to develop a workable solution. The AMA has written to CMS about this issue a number of times, and welcomes the opportunity to work with CMS on this issue.[5]

Finally, as CMS reviews its physician order requirements, we ask that CMS require the concurrence of the admitting or treating physician to retroactively change patient admission status. Physicians are concerned with the practice of some hospitals to utilize external consultants or non-admitting personnel to later alter physicians' admission decisions, as is currently authorized by CMS rules. CMS should consider the prevalence of this activity and make clear that the admitting or treating physician must concur with changes in patient status.

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[4] E.g.: Centers for Medicare and Medicaid Services. "Hospital Inpatient Admission Order and Certification." January 30, 2014. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf.

[5] See, e.g.: AMA Letter to CMS, June 27, 2014, https://download.ama-assn.org/resources/doc/washington/x-pub/hospital-inpatient-prospective-payment-systems-comment-letter-27june2014.pdf;
AMA/AHA letter to CMS, November 8, 2013, https://download.ama-assn.org/resources/doc/washington/x-pub/two-midnight-suspension-letter-08nov2013.pdf;
AMA letter to CMS, June 25, 2013, https://download.ama-assn.org/resources/doc/washington/x-pub/inpatient-prospective-payment-systems-comment-letter-25june2013.pdf;
AMA letter to CMS, May 16, 2013, https://download.ama-assn.org/resources/doc/washington/x-pub/2013-05-16-ama-cms-patient-admission-status.pdf; and
AMA letter to CMS, August 31, 2012, https://download.ama-assn.org/resources/doc/washington/x-pub/2012-08-31-hopd-proposed-rule-comment.pdf.

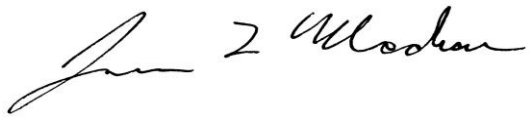
VII. CMS-Identified Overpayments Associated with Payment Data Submitted by Medicare Advantage (MA) Organizations and Medicare Part D Sponsors

CMS seeks to establish a recoupment as well as a three-level appeals process for Medicare Advantage (MA) organizations and Part D sponsors with respect to overpayments identified by CMS. The agency contemplates requesting data corrections from claims that are up to six years old. The planned appeals process would encompass reconsideration, an informal hearing, and an administrator review. **CMS should ensure that the recoupment process does not entail financial consequences or penalties for physicians, and any new appeals mechanisms under MA and/or Part D do not add to physician burden or result in additional documentation requests. In addition, we strongly object to the overly lengthy look-back period of up to six years.** Such a lengthy period would seriously undermine the stability of Medicare payments and very possibly the entire financial stability of certain providers that serve a preponderance of Medicare patients.

Conclusion

The AMA appreciates the opportunity to offer our perspective on the 2015 OPPS/ASC Proposed Rule and we look forward to working with CMS to achieve resolution of the foregoing matters. Should you have any questions, please feel free to contact Cybil Roehrenbeck, Assistant Director, Federal Affairs, at cybil.roehrenbeck@ama-assn.org, or 202-789-8510.

Sincerely,



James L. Madara, MD