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MEMORANDUM

To: ASTS

From: Rebecca Burke and Diane Millman

CC: Peter Thomas

Date: November 30, 2007

Re: 2008 Medicare Physician Fee Schedule

The FY 2008 physician fee schedule final rule was released on Thursday, November 1, 2007. We have summarized below those aspects of the final rule which we believe are relevant to ASTS and have attached a spreadsheet showing the impact on transplant services.

Overview

The final rule reflects a 10.1% reduction in the conversion factor, which will take effect January 1, 2008 unless Congress acts. The new conversion factor for 2008, as announced in the final rule, is $34.0682. Congress has intervened at the 11th hour in the last two years to prevent deep cuts in physician reimbursement, and legislation that would avert next year's reduction is currently under consideration.

As you may recall, in connection with last year's FY 2007 fee schedule, CMS announced that it would apply a 10% budget neutrality adjustment to physician Work RVUs (W-RVUs), due to the increases in work RVUs for evaluation and management services. In 2008, a similar adjustment (of approximately -12%) will be made to the W-RVUs because of increases in anesthesia work RVUs. Because transplant surgery payment primarily consists of W-RVUs, this adjustment will have a relatively high dollar impact on Medicare payment allowances for transplant procedures (as compared with

other physicians' services) in CY 2008. Most medical specialties had urged CMS to apply the budget neutrality adjustment to the conversion factor. However, despite opposition, CMS will continue, in 2008, to apply the adjustment to work RVUs. The actual adjustment factor is 0.8816 – slightly higher than the 2007 amount.

The attached spreadsheet shows 2007 and 2008 RVUs for transplant services. As you can see, most codes undergo modest decreases which are largely attributable to the work adjuster. Note that this table does not include the 10.1% reduction in the conversion factor scheduled to take effect January 1, 2008.

Backbench Codes

There have been no changes with respect to the backbench codes. CMS continues to designate the standard backbench procedures as carrier priced. There is no discussion of ASTS' previous requests to reimburse these services under Part A as organ acquisition costs.

IVIG

CMS will continue to pay an add-on fee of approximately $70 for each IVIG infusion in non-hospital settings, for one more year. Note however, that although IVIG infusions in the hospital outpatient department are also eligible for an add-on, the hospital add-on amount is only $39.