**Submitter :** Dr. jeff Rich **Date:** 08/14/2006

**Organization :** Kendall Bone and Joint Restoration

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-**
**Orthopedic Surgery**

Discussion of Comments- Orthopedic Surgery

I feel the recent Medicare payment reductions are not in good support of good healthcare. So much talk is of prevention of disease, yet one of the tests to do this, DEXA for osteoporosis, is scheduled to be slashed 80% over the coming years. As a physician who implements this in my practice, I would no longer be able to perform these tests. These changes should seriously be reviewed. This is bad medicine on Medicares part to try and accurately screen and treat these patients. Other procedures also are significantly affected such as total joint replacements. To be reduced 10-15% is unfair to the physician performing these life changing procedures. The cost of running a practice continues to increase and our reimbursements continue to decrease. You want top integrate EMR's, how are we suppose to afford this new technology. As a physician I am deeply concerned that these changes will have a major negative affect on healthcare in this country.

Best Regards,

Jeff A Rich, D.O.

**Submitter :** Dr. Nan Giordano **Date:** 08/14/2006

**Organization :** Dr. Nan Giordano

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

1. Please withdraw the proposed increase in evaluation and management codes until you have the funds to support it without taking it from someplace else. In my many years of practice I have almost without exception not received reimbursement for a 90801 with numerous explanations as to why I shouldn't be reimbursed, none of which are appropriate or accurate.

2. Do not reduce work values by ANY % for clinical social workers as the fee for psychotherapy is ALREADY below community standard and reimbursement is 50% of what is billed for mental health providers, a travesty. It is very obvious mental health services for the elderly are not valued and most of us in the field are not fooled by the bait and switch tactics politicians use, i.e. give drug benefits on one hand and with the other increase monthly premiums for the beneficiares and constantly try to reduce what is paid to providers. And when that does not work, just refuse to pay and say it is not medically necessary. The appeals of claims and review process borders on criminal at the most and unethical at the least!

**Practice Expense**

Practice Expense

Please DO NOT approve the "top down" formula to calculate practice expense as it creates a negative impact for mental health providers. Find a formula that reimburses at a fair and community standard rate. There are very few clinical social workers providing services to the elderly because we only receive 50% of what is billed and the fee for service is already $40.00 lower than the standard session in this community!

**Submitter :** Ms. Robyn Golden **Date:** 08/14/2006

**Organization :** Rush University Medical Center

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please do not reduce payments to Social Workers--we are the number 1 provider of mental health services in the country and this will dramatically reduce access to beneficiaries!

**Submitter :** **Date: 08/14/2006**

**Organization :**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Dr. McClellan,

I am a physical therapist in Newberry, SC. I have been practicing for 13 years in an outpatient setting. My professional association (APTA) has encouraged its members to go back to school to get their doctorates. Per their advice, I went back to school and received my Doctorate in Physical Therapy in 2005. Post graduate studies have been quite expensive.

It is disheartening to see the proposal of CMS-1512-PN that will in essence reduce reimbursement from 6-10% in 2007. Coupled with rising inflation and gas prices, it is difficult to provide the quality care that I have always given in the past with constant cuts. The elderly are ultimately the ones who will suffer. What is also concerning is the fact that the SGR formula projects cuts up to 37% by 2015. Furthermore, by increasing payment E/M services, the physicians will be able to offset CMS cuts. However, physical therapists are unable to bill E/M codes and will in no way benefit from such benefits

I feel like physical therapists are being made the scape goat for much of the CMS cuts in healthcare. It seems that if we do not have cuts in reimbursement, then we are facing caps. What other health practitioners are faced with caps and the inability to bill for E/M services other than therapists (PTs, OTs, SLPs)?

In conclusion, I ask that you refrain from making such drastic cuts to the physical therapy codes as proposed in CMS-1512-PN. We are not privy to billing E/M services to offset such drastic cuts. I strongly encourage you to reconsider this unfair (for PTs) proposal. Would you or one of your representatives please contact me about this very important issue concerning our profession?
(803) 276-7320 Sincerely, Mark

**Submitter :** Dr. John Chau **Date:** 08/14/2006

**Organization :** Comprehensive Health Center

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please consider increase the medicare re-imbursement pay to doctors. we are not able to see or refer the patients as a resul;t of the low re-imbursement rate and patient care will be jeopardized as a consequence.
Thanks.

**Submitter :** **Gretchen Pauley** **Date: 08/14/2006**

**Organization :** **Gretchen Pauley**

**Category :** **Social Worker**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

I am writing to urge your committee to consider the impact that a 14 percent reimbursement reduction for mental health practitioners will have on mental health care. We recently saw the impact of the Medicare D program on the mentally ill community -- our most vulnerable population falling through the cracks again. If you reduce practitioner's fees, you naturally guarantee fewer providers who can afford to take care of Medicare patients, our country's most fragile citizens. We are a country of compassion, and we need to continue to fund programs that are not only designed to improve our quality of life, but to assist those individuals with the most meager means to live fully and productively. Gone are the days when becoming a health care provider means being well compensated. If you force practitioners, in order to make our mortgages, to move to ever more privatization, you force those in the most need, our Medicare population, to get their care, if at all, in places where the resources are barely adequate.

From a fiscal point of view, it only makes sense to continue programs that are at the primary and secondary levels of care. Terciary care costs will no doubt increase if Medicare beneficiaries lose the ability to find experienced providers. Integrating mental health into overall healthcare has proven again and again to reduce the burden on the health care system.

Please reconsider this proposal.

Regards,

Gretchen Pauley, LICSW
Brookline, Massachusetts

**Submitter :** Mrs. Hannah Shivery **Date:** 08/14/2006

**Organization :** Mrs. Hannah Shivery

**Category :** Social Worker

**Issue Areas/Comments**

**Other Issues**

Other Issues

I am writing out of concern for CMS-1512-PN, which proposes cuts in medicare reimbursement for clinical social work of 14% by the year 2010. Social Workers who provide clinical services are highly educated professionals who deserve to earn a liveable wage. A cut in the medicare reimbursement rate for clinical services devalues the profession and limits the number of providers who will be able to afford to accept clients with medicare. This does a disservice to those who most need clinical services and puts people at risk for not getting the treatement that they need. By cutting costs for clinical services, costs for other services will likely rise. There will likely be more emergency room visits for psychiatric needs and a higher rate of incarceration for those not receiving treatment. Both of these options are much more costly than providing out-patient preventive clinical services. Please reconsider the plan to reduce the medicare reimbursement rate.
Sincerely,
Hannah Shivery

**Submitter :** **Date: 08/14/2006**

**Organization :**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1512-PN-1428-Attach-1.DOC

Attachment #1428

To: CMS
Subject: 5 year Review and the proposed Medicare Physician Fee Schedule regarding RVU changes.
Date: 8-14-06
Dear CMS Representative,

I have been a Physical Therapist for 27 years and have a great love for patient care. I have watched as healthcare has morphed into its present state of chaos. I am not in favor of the new proposed 5 year rule since it will affect the amount and quality of care for most of the patients in the CMS system. I do understand that the increased demands on the system merit some changes, but this ruling is a random and globally based effort at cutbacks. I do have some ideas that would better serve the system and the patient population it serves than this global ruling would, and have listed them for your review:

1. I would recommend stopping payment of **outpatient** care provided **in the homes,** or limit the fee due to the RVU and facility cost being much less than that of a clinic with full staff and facilities. Therapists working out of their car do not have the overhead that an outpatient clinic does. Home Health provides the services needed in the home with a transition to outpatient clinics for follow up care. This type of service has become a new business boom in my area and I would like to see the money used for patients who are progressing into functional outcomes.
2. TENS units are issued at $60.00-$200.00/month payments for months or a year when TENS units can be purchased for $60.00!! Why would you rent...it would be cheaper to buy a TENS unit for a patient than to rent for a single month! How many units are rented in a year Nationwide?
3. I would suggest you assign billing numbers to all therapists and create automatic edits for those with more than 30 units billed on any given date. There are only 32 15 minute units in an 8 hour day. It would be less than quality care otherwise. A system like this would assist to identify fraudulent claims.
4. Discontinue "incident to" charges. Only therapists should be able to bill for therapy. This would be easily done with the assigned billing numbers and limited billing unit edits.
5. I would like to see charges brought against the therapist and not just the institution in the case of fraud. I don't recall any of the Health South therapists being charged, but the fraudulent billing was issued under their approval and signature. Why were the therapists not called to justice as well? How else will you demand a culture of ethics and compliance in the therapy community? Pressure to conform to fraudulent practice needs to have a counter-pressure of fear of prosecution! I think the lack of legal ramification to individual therapists is part of the apathy in regards to improper and fraudulent billing practices.

I do understand the need for efficacy and the looming healthcare crisis. I am also aware of over-utilization by therapists. I would like to see the answer to this crisis not be one of global random reductions, but think it best to let those therapists who provide the best patient outcomes in the least amount of time (quality based evidence practice) take over the fiscal landscape. This would be a win-win for all involved.

**Submitter :** Dr. Marybeth Yuskavage **Date:** 08/14/2006

**Organization :** Clovis Medical Group

**Category :** Physician

**Issue Areas/Comments**

**Regulatory Impact Analysis**

Regulatory Impact Analysis

I would like to voice my grave concern on the proposed reduction in reimbursement for the DXA scan for the use in osteoporosis diagnosis and treatment. There has been an error made in the calculation of cost of equipment due to the fact that ours and other machines use fan beam technology rather than the pencil beam technology that has been found to be less accurate. I am involved in the treatment of osteoporosis and utilize my DXA to give the correct management recommendations to my patients. Medicare has recently acknowledged the importance of osteoporosis diagnosis and primary prevention to avoid excessive costs in the future due to fractures.

I am a primary care physician and I need to utilize the most up to date equipment for my services. The lack of accurate calculation of my up front expenses in providing this technology as described above will impact greatly on the service I can provide. I am the first step in many of the chronic disease states that can be cared for at a lower cost. Please do not be penny wise and pound foolish in your decision to cut the reimburesement levels to those of us who are in the best position to impact on the care of those patients who may lose the ability to have early detection and care of their oseteoporosis. I ask that you reexamine the data with the most accurate cost of equipment including those that use fan beam technology.

Yours truly

Marybeth Yuskavage, M.D.

**Submitter :** **Ms. Jennifer Shay** **Date: 08/14/2006**

**Organization :** **Providence Elder Place**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The proposed reductions in coverage to Social Workers is very unfortunate and unwise. I do not support CMS-1512-PN and encourage you to consider this decision wisely. Thank you.
Jennifer Shay, MSW

**Submitter :** **Date: 08/14/2006**

**Organization :**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Medicare's reimbursement rate is already so low that I am no longer willing to accept clients with Medicare only. To reduce rates further will create an even more substantial problem for individuals to find a clinician who will see them.

**Submitter :** **Ms. Elizabeth Ojakian** **Date: 08/14/2006**

**Organization :** **Private Psychotherapy Practice**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Sir or Madam

I am very distressed by the plan to cut reimbursement to Medicare providers. As a licensed social worker I would be impacted and would have to consider whether I would choose to continue counseling Medicare clients. As a 62 year old person, I am also concerned that within a few years I will have difficulty finding a provider who would treat me. Reducing the fees of providers is a short-sighted and ineffective way to attempt to get our budget in order. Please do not reduce the reimbursement any lower than they already are.

Thank you.

Elizabeth Ojakian, LCSW, CASAC, CEAP

**Submitter :** Mr. Paul Lee **Date:** 08/14/2006

**Organization :** Mr. Paul Lee

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please do not reduce CMS rates for social workers. The difference between rates paid to M.D.'s and other providers is already disproportionate. Please don't hurt those at the bottom of the pay scale. Thank You

**Submitter :** **Shay Strickland** **Date: 08/14/2006**

**Organization :** **Medical University of South Carolina**

**Category :** **Individual**

**Issue Areas/Comments**

**Other Issues**

Other Issues

Please act to stop the proposed medicare cuts for anesthesia providers. We are currently being reimbursed at only 37% market value, whereas other healthcare providers are at 80% of market value. We are not asking for a raise, but rather the ability to continue to provide quality access to healthcare services to all Americans. Anesthesia is a vital component of healthcare and we ask that you think of the patients' best interest. Nurse anesthetists continue to work hard to ensure patient safety and satisfaction while minimizing medicare costs and improving patient outcomes through research based practice. Thank you for your time and consideration.

Sincerely,
Shay Strickland, SRNA
Summerville, South Carolina

**Submitter :** Mr. bryan seder **Date:** 08/14/2006

**Organization :** Seder Physical Therapy, LLC

**Category :** Physical Therapist

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a Physical Therapist that has been in private practice for over ten years. I am very concerned about the proposed cuts to Medicare in 2007. I would like to see that CMS transition the changes to the work relative value units (RVUs) over a 4 year period to ensure that patients continue to have the access they deserve to valuable health care services.

-It is unreasonable to propose policies that pile cuts on top of cuts as would be the case with the 5 year review rule. This would impose additional cuts on top of the SGR (Sustainable Growth Rate)

-As a Physical Therapist 2007 could be a devastating year due to the fact that we can not bill for E/M codes thus we will not get any benefit from increased payment.

-If payment is cut so severely patient access to many elderly and disabled will be greatly harmed.

-I understand that CMS realizes the importance of increasing payment for E/M services to allow better management of illnesses by Physicians and this is very important, but the value of all Medicare providers who provide these services needs to be acknoweledged. Physical therapists services are being reduced in value even though we spend a significant amount of time in face to face consultations and treatment of our patients.

Thank you in advance for considering these comments and the potential harm that may occur.

Sincerely,
Bryan J Seder MPT
Sederpt@yahoo.com

1105 Renee Circle
Feasterville, PA 19053

**Submitter :** Ron Unger LCSW **Date:** 08/14/2006

**Organization :** Ron Unger LCSW

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

A 14 percent reimbursement cut will very likely force me to discontinue service as a Medicare provider. Rates are already extremely low. Various clinics I am also associated with already will not provide services to people who are only insured by Medicare.
I request CMS to not reduce work values for clinical social workers effective January 1, 2007, and I request CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers. I also request CMS not to approve the proposed "bottom up" formula to calculate practice expense. Thank you for your attention to these issues.

**Submitter :** Dr. Steven Sanderson **Date:** 08/14/2006

**Organization :** Dr. Steven Sanderson

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

The ACP's misguided and self-serving advice to enhance work RVUs for E/M services is a travesty. It is a clear attempt to diminish the value of specialty medicine and shift reimburement to primary care. The gate-keeper model of medicine, where primary care determines the need for specialty service has been shown to be an inefficient and expensive means of managing health-care costs in the United States. By enhancing E/M reimbursement at the expense of specialists (who I might add train many additional years to develop their expertise) inappropriately rewards primary care providers.

In addition, at the sky-rocketing rate of malpractice for specialists, a relative deflation of work RVU reimbursement will continue to drive much needed specialists into early retirement. It also threatens our entire country (particularly rural areas) with a lack of specialty service by qualified specialists.

The notion of enhancing work RVUs for one area of medicine and in effect decrease reimbursement for another (ie--specialty medicine) is an extremely slippery slope. It would be fool-hardy to believe that if such a motion was passed, the governing bodies of large organizations from multiple specialties would see this as the beginning of a turf war. We are professionals. We do not steal from one another. To pass such an idea would forever change the collegial relationship primary and specialty care regards one another.

No one would argue that primary care physicians are not an integral piece to the health care puzzle. However, to change the playing field and reward Internists and Family Phyisicians at the expense of their specialty colleagues is gaming the system. It is short-sighted, mean-spirited, and not in the best interest of medicine now or in the long term.

Steven Sanderson, MD
Plymouth, Minnesota

**Submitter :** **Ms. Claire Caines** **Date: 08/14/2006**

**Organization :** **Caines Center For Psychotherapy**

**Category :** **Social Worker**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

I am writing to request that the fees paid to Clinical Social Workers NOT be reduced as propsed. I am a licensed clinical social worker with over 23 years of experience. I have worked hard at becoming educated and competent at providing psychotherapy to my clients, including those covered by Medicare. My clients rely on me to help them through difficult times and bring them to an improved state of functioning. I submit for your consideration that it poses a hardship to me and my clients if fees are reduced. Physicians generally earn higher incomes than social workers. Why penalize the lowest wage earners? Thank you for your consideration.

**Submitter :** Ms. Judy Giles **Date:** 08/15/2006

**Organization :** Caregiver Support Systems, LLC

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

I urge CMS not to cut the reimbursement fees for Clinical Social Workers. It will most certainly affect their practices as Medicare Providers and adversely affect the low income elderly in nursing homes and living in the community. There is a shortage of professionals to provide these services. The cut will create additional shortages, as Clinical Social Workers decide they cannot afford the reduction.

I am now qualified to sit for the LCSW Exam. My desire is to be of service to the elderly who need it the most. Please do not make this a hardship on the small percentage of Social Workers who have chosen to work in this field.

Do not reduce the work values of clinical social workers effective January 1, 2007. Elderly and handicapped individuals need our special expertise and empathetic interventions.

How can you propose to increase the evaluation and management codes when the funds are not available to increase reimbursement for all Medicare providers.

Please select a reasonable formula to calculate practice expenses for Clinical Social Workers who have very little practice expense as providers. The "bottom up" formula will create a negative impact for these professionals.

Finally, the 14 % fee reducution will only create hardships on existing clinical social workers and discourage those of us who aspire to do this work.

Sincerely,

Judy L. Giles, LMSW, CMC
Geriatric Care Manager

**Submitter :** **Dr. Mohammad Memon** **Date: 08/15/2006**

**Organization :** **Grays Harbor Internal Medicine**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Reduction in the reimbursment of Bone Density and VFA will result in less availability of dexa scan and it will deprive older folks from quality care as well as delay in diagnosis and treatment of osteoporosis. This will result in increase fractur and complication which would result in more health care cost.

**Submitter :** Dr. Mark Ansel **Date:** 08/15/2006

**Organization :** Mark G. Ansel, Ph.D., LCSW

**Category :** Social Worker

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

I find it appalling that you would consider decreasing fees for Social Workers. While I do not take Medicare now, a decrease in fees would solidify my decision as I could not afford to business with this needy clientele. Furthermore, a Clinical Social Worker in independent practice has the same expenses to run an office as other healthcare professionals, and a cut would cause many who are delivering a valuable service at a cost effective price to reconsider their participation in Medicare.

**Submitter :** Dr. gary unzeitig **Date:** 08/15/2006

**Organization :** Dr. gary unzeitig

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

reimbursement for mastectomy codes are very low for work performed. 191960, partial mastectomy is several hours in the OR waiting for margin assessments by the pathologist and often re-excision of a margin. 19182 subcutaneous mastectomy in no way assesses the work and expertise involved with areolar sparing mastectomies and skin sparing mastecomies for cancer. All the remainder of breast surgical codes for mastectomy are undervalued for time, malpractice, E&M, etc.

**Submitter :** Mrs. Beverly Carr, LCSW **Date:** 08/15/2006

**Organization :** Mrs. Beverly Carr, LCSW

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

As a clinical social worker, I urge CMS to reconsider their plan to lower reimbursement for Medicare clients. It is difficult enough for these clients to receive timely and effective treatment. By lowering reimbursement fees, Social Workers will have a difficult time continuing to accept these clients. Anyone seeing these clients will take a 14% decrease in pay by 2010, while there will be a 10% INCREASE in management and evaluation codes, which will NOT impact social workers. Therefore I request that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers.

**Submitter :** Mr. Dan Simonson **Date:** 08/15/2006

**Organization :** Spokane Eye Surgery Center

**Category :** Nurse

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am writing with my concerns about the projected 10% cuts planned for Certified Registered Nurse Anesthetists (CRNAs). The ostensible reason for these cuts is to maintain "budget neutrality", a noble goal but completely unrealistic in light of the fact that current reimbursement is at 30% of market value. This cut should be debated separately as a policy change, not as merely the innocuous side effect of the social engineering that you are planning with the rest of the changes in the fee schedule. A 10% cut in reimbursement is going to cause widespread disruption in how anesthesia care is delivered, and you need to address that directly.

**Submitter :** Dr. Wayne Koch **Date:** 08/15/2006

**Organization :** American Head and Neck Society

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**Discussion of Comments-
Otolaryngology and Opthalmology**

Discussion of Comments- Otolaryngology and Opthalmology

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

**Submitter :** Mr. Davis Graham **Date:** 08/15/2006

**Organization :** Manatee Diagnostic Center, Ltd.

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

These Changes will have a significant negative impact on patient access to Osteoporosis screening.
There are errors as to the assumption regarding equipment cost of DXA by calculating cost information using pencil-beam technology, where we and most of the industry uses fan beam. This assumption is a serious underestimation of the actual costs of providing state of the art osteoporosis screening.
This cut in DXA reimbursement as proposed will negatively impact women's access to this important test.

**Submitter :** Dr. Kara Nance **Date:** 08/15/2006

**Organization :** Riverside Medical S.C.

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a physician who currently does osteoporosis screening for our practice in the Chicago suburbs. After being made aware of the impact that osteoporosis is having on our citizens, especially those over 65, I became interested in offering this service to our patients at our office. The people who most benefit from this service are older people, who often find it difficult to leave the house multiple times for a variety of different tests. By offering this service to our patients here at our office on the same day as another appointment ensures that many more patients are adequately screened. After investing 80,000 dollars last year for this equipment for which we now have a five year lease, I am very concerned that I will not be able to cover my overhead and still be able to offer this essential service to our patients. I cannot see how the new fee schedule will cover the costs for this service, and the availability of bone densitometry will be dramatically reduced in this country. When taking into account the fee schedule it is important to remember not only the cost of the VERY expensive machinery, but also that of the techs, the schedulers, the billing people, and maintenance fees. Not to mention the opportunity cost of the space the machine currently uses. Please take these issues into account when making such a dramatic decision.

Sincerely,

Kara Nance

**Submitter :** Mr. Joseph Lynch **Date:** 08/15/2006

**Organization :** Newman Avenue Associates PC

**Category :** Social Worker

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Dear Sir or Madam:

I am writing concerning CMS-1512-PN proposal for a 14% reimbursement cut . I respectfully request that CMS not reduce work values by &% for clinical social workers that is proposed to be effective January 1, 2007. Ialso request tath CMS not approve the porposed "top down" formula to calculate practice expense. An alternative formula that does not create a negative impact for mental health providers must be developed. I request taht CMS withdraw the proposed \increase in evaluation and management codes until they have funds to increase reimbursement for all Medicare providers.

This proposed change will directly have an immediate negative impact on my practice. While as a social worker I have always been committed to provide services to the multiproblem families and children tath medicade funds, I am not willing to provide these services to my own detrement. I have a busy clinical practice. I have 30 years of clinical experience and much of my experience is helping sexually abused children and the perpetrators of abuse. I already have to work long hours to meet my practice expenses. My actual dollar collected per hour of service has not changed since 1990. I don't know any other area of the economy that pays 1990 rates in 2006. This proposed change will make your client population the lease attractive to schedule in any hour I have open.

In summary this is bad public policy to create a reimbursement rate that will have the effect of reducing the number of clinical social worker hours that are available to your clients. If your goal is to cut services to this population, then do it directly- just cut the services. This proposal is a back door public policy that will hurt all of the clients served by medicade and medicare.

In my area of the state the medicade reimbursement rate has already impaced the availability of Dental services and your clients must travel over 140 miles round trip and wait months for services. You are about to make the same mistake with mental health services. I strongly urge you to reconsider and not pass this proposed change.

Sincerely,

Joseph G. Lynch LCSW

**Submitter :** Dr. Wayne Koch **Date:** 08/15/2006

**Organization :** American Head and Neck Society

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1512-PN-1449-Attach-1.PDF

Attach FF
1449

**American Head and Neck Society**
11300 W. Olympic Blvd. Suite 600, Los Angeles, CA 90064
phone (310) 437-0059 fax (310) 437-0585

August 14, 2006

The Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

RE: CMS-1512-PN: Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Submitted electronically at http://www.cms.hhs.gov/eRulemaking

Dear Dr. McClellan:

On behalf of the members of the American Head and Neck Society (AHNS), I am pleased to submit the following comments on the Proposed Rule published in the *Federal Register* on June 29, 2006. AHNS is the primary organization representing subspecialists who perform surgical procedures for cancer of the head and neck. As requested, we will cite each Proposed Rule Section that we are commenting on.

***DISCUSSION OF COMMENTS - OTOLARYNGOLOGY***

We are providing comments for eight codes where the Agency disagreed with the RUC recommendation. For all of these codes, the rationale in the Proposed Rule states: "The median values for intra-service times were accepted by the RUC for these services, which is an indication that a value other than the 75th percentile for work also may be appropriate." No rationale for comparison services at the proposed work RVUs was provided. To assist the Agency with review of these codes, and as requested by the Agency, our comments will discuss how the work associated with a given CPT code is analogous to the work in other services and we will provide a rationale for recommending that CMS accept the RUC recommendations.

| CPT | Descriptor | 2005 Work RVU | Requested Work RVU | RUC REC | CMS Proposal | Proposed Work RVU | 2004 Util |
|---|---|---|---|---|---|---|---|
| 31360 | Removal of larynx | 17.05 | 28.00 | 28.00 | Disagree/- | 24.00 | 668 |
| 31365 | Removal of larynx | 24.12 | 37.00 | 37.00 | Disagree/- | 31.50 | 513 |
| 31367 | Partial removal of larynx | 21.83 | 28.00 | 27.36 | Disagree/- | 24.00 | 74 |
| 31368 | Partial removal of larynx | 27.05 | 36.00 | 36.00 | Disagree/- | 30.50 | 61 |
| 31390 | Removal of larynx & pharynx | 27.49 | 40.00 | 40.00 | Disagree/- | 35.00 | 90 |
| 31395 | Reconstruct larynx & pharynx | 31.04 | 44.00 | 44.00 | Disagree/- | 39.50 | 71 |
| 41155 | Tongue, jaw, & neck surgery | 27.68 | 40.00 | 40.00 | Disagree/- | 36.00 | 548 |
| 42845 | Extensive surgery of throat | 24.25 | 32.00 | 32.00 | Disagree/- | 29.00 | 54 |

Overall Discussion

Although these procedures are performed at a low frequency, the CMS proposed work RVUs will create rank order anomalies. These head and neck oncology procedures represent the most complex, lengthy, and demanding cancer operations performed by our specialty. The AHNS conducted a standard AMA/RUC survey for these eight codes, which are all performed by *subspecialists* with *focused* expertise. The reference service list that accompanied the survey included procedures that may be familiar to otolaryngologists and head and neck surgeons, however, the majority of codes that would definitely be familiar to head and neck surgeons with a focused expertise were under review and could not be included in the reference list.

In our recommendations to the RUC, we noted that the survey work RVU estimations may have been underestimated for these eight codes because the most frequently cited references were familiar codes (eg, thyroidectomy) in the lower work RVU range of the reference list. As noted above, familiar procedures with higher work RVUs were under review and not available to use as references.

In our rationale for recommendations for these codes, we presented comparisons to codes on the multispecialty points of comparison (MPC) table, a standard comparison that both the RUC and the Agency often use in setting relativity within and between specialty codes. In our recommendations and in discussions at the RUC, we also compared these procedures to other major oncologic resections that have similar length, complexity, and impact of decision making, such as 58210 (radical abdominal hysterectomy with lymphadenectomy); 47120 (hepatectomy, partial lobectomy); and 48153 (pancreatectomy, Whipple). In comparison to the cited major oncologic operations, the RUC agreed that the head and neck resections typically require more postoperative care that included management of wound problems in radiated and contaminated fields, and in the recovery of speech, swallowing, airway function and upper extremity usage.

The outcome of discussions at the RUC was that the survey median work RVUs for these eight low volume codes were underestimated and would create rank order anomalies. For these eight codes, the RUC recommended work RVU would be a better relative value in comparison to other head and neck codes and other major operations of other specialties. Comments for each code are presented below.

31360 Laryngectomy; total without radical neck dissection

The reference code cited most often in the RUC survey for 31360 was CPT 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (RVW= 20.54). The intra-op time is only slightly less for 60252, but the LOS is four days shorter. Code 31360 requires more preservice work related to discussing/preparing for emergency airway access and reconstruction as well as patient/family work to discuss voice rehabilitation options. Postoperatively, these patients have a stoma to manage and require monitoring of swallowing and diet after discharge (they are not able to eat by mouth for 7-10 days). We believe the choice of this reference code and the use of magnitude estimation resulted in an underestimation of the total work for 31360. In terms of RVW, time, and post-op work, the RUC recommended work RVU (28.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

| | CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|---|
| Survey | 31360 | Laryngectomy; total without radical neck | 28.00* | 714 | 8 | 6 |
| Ref | 60252 | Thyroidectomy; with limited neck dissection | 20.54 | 446 | 4 | 3 |
| MPC | 45110 | Proctectomy; complete, AP with colostomy | 27.96 | 624 | 9 | 4 |
| MPC | 61510 | Craniectomy, for excision brain tumor | 28.41 | 609 | 7 | 4 |
| MPC | 27134 | Revision total hip arthroplasty | 28.48 | 608 | 8 | 3 |

* RUC recommended value

Additionally, by proposing the median work RVU (24.00) for 31360, the Agency has created an anomaly within the families of codes encompassed by our specialty. For example, 31230 *Maxillectomy with orbital exenteration* was approved by the RUC with CMS agreement at a median work RVU of 28.00. The total time and visits for 31230 and 31360 are very similar. Also, 31225 *Maxillectomy without orbital exenteration*, which involves less work, was approved by the RUC with CMS agreement at a median work RVU of 24.00.

| CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|
| 31360 | Laryngectomy; total, without radical neck | 28.00* | 714 | 8 | 6 |
| 31225 | Maxillectomy without orbital exenteration | 24.00 | 568 | 5 | 5 |
| 31230 | Maxillectomy with orbital exenteration | 28.00 | 647 | 6 | 5 |

* RUC recommended value

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 28.00 work RVUs for code 31360.**

<u>31365 Laryngectomy; total with radical neck dissection</u>

Code 31365 adds radical neck dissection to the work of code 31360. The survey median work RVU for 38720 *Radical neck* (20.00) was approved by the RUC with CMS agreement. In reviewing 31365, the RUC considered the incremental work of radical neck dissection in it's recommended work RVU, as approximately 50 percent of the work RVU for 38720 (i.e., utilization of the multiple procedure payment rule). By proposing the median work RVU (31.50) for 31365, the Agency has created an anomaly within the families of codes encompassed by our specialty.

Additionally, we present three MPC codes that support the RUC recommendation.

| | CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|---|
| Survey | 31367 | Laryngectomy; total, with radical neck | 37.00* | 838 | 9 | 6 |
| MPC | 19364 | Breast reconstruction with free flap | 40.94 | 730 | 5 | 6 |
| MPC | 33405 | Replacement, aortic valve | 34.95 | 567 | 8 | 4 |
| MPC | 33426 | Valvuloplasty, mitral valve | 32.95 | 571 | 7 | 3 |

*RUC recommended value

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 37.00 work RVUs for code 31365, or at a minimum, the work RVU for 31365 should be 10.00 work RVUs greater than 31360 to account for the incremental work of the radical neck dissection (38720; work RVU=20.00).**

31367 Laryngectomy; subtotal supraglottic, without radical neck dissection

The code cited most often in the AHNS survey as a reference for 31367 was CPT 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (RVW= 20.54). The intraoperative time is the same for the two procedures, but 31367 requires more preservice work related to discussing/preparing for emergency airway access. LOS is significantly greater for 31367 because these patients will have their airway compromised and need a tracheotomy that will require monitoring for swallowing and diet. We believe the choice of this reference code and the use of magnitude estimation resulted in an underestimation of the total work for 31367. In terms of RVW, time, and post-op work, the RUC recommended work RVU (27.36) is a more reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

| | CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|---|
| Survey | 31367 | Laryngectomy; supraglottic without radical neck | 27.36* | 675 | 7 | 6 |
| Ref | 60252 | Thyroidectomy; with limited neck dissection | 20.54 | 446 | 4 | 3 |
| MPC | 27134 | Revision total hip arthroplasty | 28.48 | 608 | 8 | 3 |
| MPC | 45110 | Proctectomy; complete, AP with colostomy | 27.96 | 624 | 9 | 4 |
| MPC | 61510 | Craniectomy, for excision brain tumor | 28.41 | 609 | 7 | 4 |

* RUC recommended value

Additionally, by proposing the median work RVU (24.00) for 31367, the Agency has created an anomaly within the families of codes encompassed by our specialty. For example, 31230 *Maxillectomy with orbital exenteration* was approved by the RUC with CMS agreement at a median work RVU of 28.00. The total time for 31230 and 31367 are very similar. Also, 31225 *Maxillectomy without orbital exenteration*, which involves less work, was approved by the RUC with CMS agreement at a median work RVU of 24.00.

| CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|
| 31367 | Laryngectomy; supraglottic without radical neck | 27.36* | 675 | 7 | 6 |
| 31225 | Maxillectomy without orbital exenteration | 24.00 | 568 | 5 | 5 |
| 31230 | Maxillectomy with orbital exenteration | 28.00 | 647 | 6 | 5 |

* RUC recommended value

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 28.00 work RVUs for code 31367.**

31368 Laryngectomy; subtotal supraglottic with radical neck dissection

Code 31368 adds radical neck dissection to the work of code 31367. The survey median work RVU for 38720 *Radical neck* (20.00) was approved by the RUC with CMS agreement. In reviewing 31368, the RUC considered the incremental work of radical neck dissection in it's recommended work RVU as approximately 50 percent of the work RVU for 38720 (i.e., utilization of the multiple procedure payment rule). By proposing the median work RVU (30.50) for 31368, the Agency has created an anomaly within the families of codes encompassed by our specialty.

Additionally, we present three MPC codes that support the RUC recommendation.

| | CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|---|
| Survey | 31368 | Laryngectomy; supraglottic with radical neck | 36.00* | 804 | 8 | 6 |
| MPC | 19364 | Breast reconstruction with free flap | 40.94 | 730 | 5 | 6 |
| MPC | 33405 | Replacement, aortic valve | 34.95 | 567 | 8 | 4 |
| MPC | 33426 | Valvuloplasty, mitral valve | 32.95 | 571 | 7 | 3 |

*RUC recommended value

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 36.00 work RVUs for code 31368, or at a minimum, the work RVU for 31368 should be 10.00 work RVUs greater than 31367 to account for the incremental work of the radical neck dissection (38720; work RVU=20.00).**

42845 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap

The reference code cited most often in the RUC survey for 42845 was 60254 *Thyroidectomy, total or subtotal for malignancy; with radical neck dissection* (RVW=26.95). Compared with 42845 the intra-op time, LOS, and office visits are all less for 60254. Patients requiring 42845 remain in the hospital for a long time to monitor the flap, and because their overall health and nutrition are compromised as a result of the large active tumor in the throat, and most often because of previous chemotherapy and radiation. We believe the choice of reference code 60254 and the use of magnitude estimation resulted in an underestimation of the total work for 42845. In terms of RVW, time, and post-op work, the RUC recommended work RVU (32.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

| | CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|---|
| Survey | 42845 | Radical resection of tonsil; closure w flap | 32.00* | 758 | 10 | 4 |
| Ref | 60254 | Thyroidectomy; with radical neck dissection | 26.95 | 476 | 4 | 3 |
| MPC | 15756 | Free muscle/myocutaneous flap | 35.18 | 796 | 9 | 6 |
| MPC | 33405 | Replacement, aortic valve | 34.95 | 567 | 8 | 4 |
| MPC | 33426 | Valvuloplasty, mitral valve | 32.95 | 571 | 7 | 3 |

* RUC recommended value

Compared with the work RVUs for other codes performed by our specialty and surveyed and approved by the RUC with CMS agreement, valuing 42845 at the RUC recommended value of 32.00 maintains rank order.

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 32.00 work RVUs for code 42845.**

41155 Glossectomy; composite resection with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)

The reference code cited most often in the RUC survey for 41155 was 60254 *Thyroidectomy, total or subtotal for malignancy; with radical neck dissection* (RVW=26.95). We believe the choice of reference code 60254 and the use of magnitude estimation resulted in an

underestimation of the total work for 41155. In terms of RVW, time, and post-op work, the RUC recommended work RVU (40.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

| | CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|---|
| Survey | 41155 | Glossectomy; composite with RND (Commando) | 40.00* | 899 | 10 | 6 |
| Ref | 60254 | Thyroidectomy; with radical neck dissection | 26.95 | 476 | 4 | 3 |
| MPC | 33405 | Replacement, aortic valve | 34.95 | 567 | 8 | 4 |
| MPC | 33426 | Valvuloplasty, mitral valve | 32.95 | 571 | 7 | 3 |
| MPC | 19264 | Breast reconstruction with free flap | 40.94 | 730 | 5 | 6 |

* RUC recommended value

Additionally, the RUC recommendation maintains rank order within and between the families of head and neck surgical procedures and with other major oncologic resections that have similar length, complexity, and impact of decision making, such as 45126, 47120, and 48150, as shown below.

| CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|
| 41155 | Glossectomy; composite with RND (Commando) | 40.00* | 899 | 10 | 6 |
| 45126 | Pelvic exenteration for colorectal malignancy | 45.09 | 866 | 9 | 4 |
| 47120 | hepatectomy, partial lobectomy | 35.45 | 730 | 9 | 4 |
| 48150 | Pancreatectomy, Whipple | 47.93 | 1078 | 13 | 4 |

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 40.00 work RVUs for code 41155.**

31390 Pharyngolaryngectomy, with radical neck dissection; without reconstruction

CPT 60254 *Thyroidectomy with radical neck dissection* (RVW=26.95) and CPT 43107 *Total esophagectomy without thoracotomy; with pharyngogastrostomy* (RVW=39.94) were cited equally as key references for 31390. We believe that 43107 is a better reference code because of its very similar total work. Further, the choice of reference code 60254 and the use of magnitude estimation resulted in an underestimation of the total work for the survey respondents who chose this code. In terms of RVW, time, and post-op work, the RUC recommended work RVU (40.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference codes as shown below.

| | CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|---|
| Survey | 31390 | Pharyngolaryngectomy, RND, w/o reconstruct | 40.00* | 920 | 9 | 6 |
| Ref | 43107 | Esophagectomy, total, w/o thoracotomy | 39.94 | 912 | 11 | 4 |
| Ref | 60254 | Thyroidectomy; with radical neck dissection | 26.95 | 476 | 4 | 3 |
| MPC | 19264 | Breast reconstruction with free flap | 40.94 | 730 | 5 | 6 |
| MPC | 33405 | Replacement, aortic valve | 34.95 | 567 | 8 | 4 |
| MPC | 33426 | Valvuloplasty, mitral valve | 32.95 | 571 | 7 | 3 |

* RUC recommended value

Additionally, the RUC recommendation maintains rank order within and between the families of head and neck surgical procedures and with other major oncologic resections that have similar

length, complexity, and impact of decision making, such as 45126, 47120, and 48150, as shown below.

| CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|
| 31390 | Pharyngolaryngectomy, RND, w/o reconstruct | 40.00* | 920 | 9 | 6 |
| 45126 | Pelvic exenteration for colorectal malignancy | 45.09 | 866 | 9 | 4 |
| 47120 | hepatectomy, partial lobectomy | 35.45 | 730 | 9 | 4 |
| 48150 | Pancreatectomy, Whipple | 47.93 | 1078 | 13 | 4 |

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 40.00 work RVUs for code 31390.**

31395 Pharyngolaryngectomy, with radical neck dissection; with reconstruction

CPT 43107 *Total esophagectomy without thoracotomy; with pharyngogastrostomy* (RVW=39.94) was cited as the key references for 31395. Compared with the reference code, 31395 requires 100 minutes more intra-operative time, two additional office visits, and one less hospital visit. The RUC recommended an incremental value for the additional work of 31395 when compared to 31390 or 43107 as 4.00 work RVUs. The RUC recommendation for 31395 maintains rank order within and between the families of head and neck surgical procedures and with other major oncologic resections that have similar length, complexity, and impact of decision making, such as 45126, 47120, and 48150, as shown below.

| CPT | Description | RVW | Time | HV | OV |
|---|---|---|---|---|---|
| 31395 | Pharyngolaryngectomy, RND, with reconstruct | 44.00* | 979 | 10 | 6 |
| 31390 | Pharyngolaryngectomy, RND, w/o reconstruct | 40.00* | 920 | 9 | 6 |
| 43107 | Esophagectomy, total, w/o thoracotomy | 39.94 | 912 | 11 | 4 |
| 45126 | Pelvic exenteration for colorectal malignancy | 45.09 | 866 | 9 | 4 |
| 47120 | hepatectomy, partial lobectomy | 35.45 | 730 | 9 | 4 |
| 48150 | Pancreatectomy, Whipple | 47.93 | 1078 | 13 | 4 |

* RUC recommended value

- **Based on these comments, we recommend that CMS accept the RUC recommendation of 44.00 work RVUs for code 31395.**

***OTHER ISSUES***

Postoperative Visits Included in Global Surgical Packages

In the Proposed Rule, the Agency indicated that it would apply the RUC-recommended new values for the E/M services to all surgical services with a 10- or 90-day global period. The intention of the RUC recommendation was that the full increase of the E/M would be incorporated into the surgical global periods for each CPT code with a global of 010 and 090. Further, the RUC indicated that E/M work is equivalent and a crosswalk of 100% of the E/M valuation should be bundled into the codes with global periods of 010 and 090 days, with appropriate documentation.

In the Proposed Rule, it appears that only the current incremental increases in proposed E/M services has been added to 010- and 090-day global services, and that the previous discounted

incremental difference from the first 5-Year-Review, were not reinstated. We fully agree with the intention of the RUC and request that the Agency add in the previously discounted work RVUs for all 010- and 090-day global services.

Budget Neutrality

We disagree with the Agency's decision to utilize a separate work adjuster for the work RVUs. We believe that this additional calculation is cumbersome for billing purposes. We note that Agency has previously tried and abandoned this methodology because of the difficulties it poses to providers and carriers. Instead, we suggest that the Agency apply budget neutrality adjustments to the conversion factor.

We would welcome the opportunity to answer additional questions or discuss these matters further should this be deemed necessary. My contact information is provided below.

Sincerely,

Wayne M. Koch, MD, FACS
RUC Advisor, American Head and Neck Society
Professor of Otolaryngology-Head and Neck Surgery
Johns Hopkins University School of Medicine
601 N. Caroline Street Rm 6221
Baltimore, MD 21287
410-955-4906
FAX 410-955-0035
wkoch@jhmi.edu

cc: John J. Coleman, MD, FACS
President, American Head and Neck Society

John Andrew Ridge, MD, FACS
Secretary, American Head and Neck Society

**Submitter :** **Eric Bowling** **Date: 08/15/2006**

**Organization :** **Eric Bowling**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please do not issue a fee reduction in health care for any pratitioners. Our challenge is to serve and pay our employees a lving wage and still serve those in need of our services.

**Submitter :** **Mr. Kenneth Hoglund** **Date: 08/15/2006**

**Organization :** **Mammassist**

**Category :** **Device Industry**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1512-PN-1451-Attach-1.DOC

CMS-1512-PN-1451-Attach-2.DOC

HHach #
1451

Centers for Medicare& Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

RE: CMS 1512-PN

CPT Codes 76082 and 76083

We recommend that CMS withdraw its proposed reduction for the technical component of CAD until such time that providers can differentiate between the utilization of CAD with analog or digital mammography. The CPT codes for CAD with mammography (76082, 76083) contain the phrase, "with or without digitization of film radiographic images".

*"These revisions reflect changes in medical practice, coding changes, new data on relative value components and the addition of new procedures that affect the relative amount of physician work required to perform each service required by statute."* There have been no changes to substantiate this proposed rule for the use of CAD with **analog** mammography.

Please consider- of the 8,829 certified mammography sites in the US, only 1,130 are digital- 12.7%. Of the 13,556 certified mammography units, only 11.8% (1,604) are digital.

Apparently, the vast majority of MQSA sites are **not** digital. Thus, the vast majority of mammograms are being done on film, not digitally.

The only way this can be fair to all involved if to differentiate between the digital and analog mammography sites. Until that process is in place, please reconsider this proposed change and defer it until such time as differentiation between sites is feasible.

Sincerely,

Ken Hoglund
President
Mamassist

**Submitter :** mark cotner **Date:** 08/15/2006

**Organization :** mark cotner

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments- General, Colorectal and Vascular Surgery**

Discussion of Comments- General, Colorectal and Vascular Surgery

I support the position of the American Society of Breast Diseases on the change for the re-embursment for partial mastectomy. The present system does not adequately reflect the complexity of modern techniques for breast oncologic surgery. Mark Cotner . MD

**Submitter :** **Date: 08/15/2006**

**Organization :**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**Other Issues**

Other Issues

Dear CMS Administrator,
I am a Physical Therapist in private practice and have been a practice owner for over 9 years. I currently employe 11 Physical Therapists and 3 Physical Therapist Assistants in New York City and manage 7 locations in total.
I wish to comment on the June 29th proposed notice to revise the calculation of the RVU's under the medicare physician fee schedule to at least be over a 4 year period.
The current formula is projected to trigger a 4.6% cut in payments in 2007 and 37% by 2015. These cuts will be further affected by the budget neutrality adjuster proposed in the 5 year review rule that would impose additional cuts on top of the SGR. It is unreasonable to propose policies that impose cuts on top of cuts.
These cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payments for these services is cut so severely, access to care for millions of the elderly and disabled will be jeopardized. Physical Therapists spend a considerable amount of face to face time with their patients, yet their services are reduced in value.
Please help us preserve the quality of care that we provide to our medicare beneficieries.
I thank you for your consideration of this matter.
Sincerely,
Mark Amir, PT MA
718-648-0888

**Submitter :** Mrs. Sue Schaffhauser **Date:** 08/15/2006

**Organization :** Cooper University Hospital

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am writing to express my concern that CMS is considering lowering the rate of reimbursement for DEXA (bone densitometry) examinations. Refer to file CMS-1512-PN. Through out the medical world and in particular the centers for osteoporosis have shown that the best standard for evaluating the risks for osteoporosis and re-evaluating progression of this disease is dual energy x-ray absorptometry by fan beam method. CMS is basing its reimbursement on pencil-beam technology. This causes a serious underestimation of the actual costs of the equipment needed.

I have a sister with osteoporosis. Prior to todays technology she would have had to break a bone before we could evaluate her for this desease. Countless women can now take advantage of the fan beam technology and seek medical attention before they incur injuries that cost millions of dollars each year. That alone should make us realize how important it is to make sure this important diagnostic tool is available to all. Lets not forget the men. More and more I see men having this test as well. They can get osteoporosis too.

Make sure you consider all facts. Fan beam technology is the best and we all want the best for our loved ones.

Sincerely,
Sue Schaffhauser

**Submitter :** **Ms. susan bluestone** **Date: 08/15/2006**

**Organization :** **Ms. susan bluestone**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Social workers are notoriously underpaid for services. Do not cut funds.

**Submitter :** **Patricia Repici** **Date: 08/15/2006**

**Organization :** **Patricia Repici**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1512-PN-1456-Attach-1.DOC

Attach #
11/56



CAPE MAY COUNTY
DEPARTMENT of HEALTH
4 Moore Road
Cape May Court House, N.J. 08210-1601
(609)465-1196 after hours (609) 465-1190
Fax: (609) 463-6783

August 15, 2006

Patricia J. Repici, PT
NJL 3 40QA00178700
Woodbine, NJ 08270
Email: prepici@co.cape-may.nj.us

Re: Medicare Program; Five-Year Review of Work Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan:

I have been a physical therapist practicing in Cape May County, NJ for the past 31 years. My case load is primarily geriatric out patients covered by Medicare. I would like to comment on the June 29th proposed notice setting forth proposed revisions to work relative value units and methodology for calculating practice expense RVUs. I urge CMS to not allow the severe Medicare payment cuts for physical therapists in 2007. I recommend that CMS transition the changes to the RVUs over a four year period.

The proposed policies will compound cuts in payments, beginning with the 4.6% cut to be triggered by SGR formula in 2007. Continued similar cuts will add up to 37% by the year 2015. Cuts will be additionally compounded by a budget neutrality adjuster proposed in the 5 year review rule. Cutting payment for physical therapy services in this manner jeopardizes access to care for the elderly and the disabled.

Physical therapists spend a considerable amount of time face to face with their patients. Patients tell me all the time, "you spend so much more time with me than my Doctor does". This is not mean to be derogatory toward the physician, but reflects the extra one on one time quality physical therapy care requires. The time difference is

appropriate for the service needed. I agree that Evaluation and Management code reimbursement should increase. However, physical therapists are not allowed to use these codes in their billing and will not benefit from these increases. Therefore, the services of the physical therapist are being devalued. The value of a ll Medicare providers services should be recognized.

Thank you for your consideration in this matter.

Sincerely,

Patricia J. Repici, PT

**Submitter :** **Mrs. Mary Beth Mayes** **Date: 08/15/2006**

**Organization :** **Central Va Family Physicians**

**Category :** **Other Technician**

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

Dear Sirs:

I believe that the proposed changes to the Medicare Physician Fee Schedule (CMS-1512-PN,RIN 0938-AO12,Medicar Program;Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology) have assumptions that are misleading. Operating costs and costs of equipment are more substantial than are outlined in this proposal. Cost of equipment was based on utilizing pencil-beam technology when virtually all systems now use fan beam technology and this alone is a gross underestimation of the actual costs of providing state of the art osteoporosis screening. If the cuts in DXA reimbursement are implemented, it will negatively impact women's access to this important test.

Sincerely,
Mary Beth Mayes, RDCS,RDMS,RVT,RT(R)(M),CDT

**Submitter :** Ms. Laura Groshong **Date:** 08/15/2006

**Organization :** Clinical Social Work Association

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

I am a Licensed Inde[endent Clinical Social Worker in Washington state and a member of the Clinical Social Work Association. I am writing to comment on the proposed CMS cuts to reimbursement rates as proposed in CMS-1512-PN. Clinical social workers, who provide 41% of the nation s mental health services (CSWF, 2003), are often the only mental health clinicians available to our nation s elderly. I am concerned about the impact these cuts will have on my ability to continue to provide services to Medicare enrollees. While I see most Medicare enrollees under Current Procedural Terminology (CPT) Code 90806, I am reimbursed at a level that is 25% lower than the rate for psychologists for the same codes. This has always seemed unfair, since the same codes mean the same kinds of services are being provided. However, lowering the reimbursement rates further, as the 14% proposed cuts would, would make it impossible for me to cover my business expenses and, therefore, would make it difficult to continue serving the Medicare enrollees I currently treat.

I would appreciate your withdrawing the current proposed cuts in reimbursement to LCSW mental health providers. In addition, I hope you will consider changing the inequitable reimbursement system that currently exists, and implement equal pay for equal codes.

**Submitter :** **Ms. Patricia Hartog** **Date: 08/15/2006**

**Organization :** **Ms. Patricia Hartog**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1512-PN-1459-Attach-1.DOC

Attach
#1459

PATRICIA L. HARTOG, LCSW
9233 SW 8th Street, Unit 203
Boca Raton, FL 33428
(954) 290-3768

August 15, 2006

To Whom It May Concern;

I am quite concerned by the potential 14 % reimbursement reduction for mental health providers currently being considered by CMS. The value placed on mental health in this country has been diminishing for years. The psychiatric community has switched from talk therapy to medication management. Licensed clinical social workers have filled the gap, and have done so effectively and professionally. We *earn* the reimbursement we are currently receiving from Medicare and then some.

Reducing this reimbursement will have a negative impact on my ability to continue to work with Medicare patients. To earn an income that will keep pace with the cost of living, more and more patients will have to be seen in a given day; this has a negative impact on the provider and therefore the patient. It is also discouraging to individuals who would be considering social work as a career. It is in no one's best interest for Medicare to reduce reimbursement fees. Insurance companies providing mental health coverage *including* Medicare, should be *increasing* not decreasing reimbursement.

I also strongly recommend that CMS does not reduce work values by 7 % for clinical social workers, and I ask that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers.

CMS should *not* approve the proposed *top down* formula to calculate practice expense. A formula should be selected that does not create a negative impact for mental health providers.

The theme through all these proposed changes is a devaluing of the importance of mental health treatment, and of those who provide this essential service to society.

Thank you for your consideration.

Sincerely,

Patricia L. Hartog, LCSW

**Submitter :** Dr. James Park **Date:** 08/15/2006

**Organization :** Anesthesia

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties.

The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses.

CMS should gather new overhead expense data to replace the decade-old data currently being used.

ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.

CMS must address the issue of anesthesia work undervaluation or our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine.

**Submitter :** Mrs. Lisa Velazquez-DeNapoli **Date:** 08/15/2006

**Organization :** Mrs. Lisa Velazquez-DeNapoli

**Category :** Social Worker

**Issue Areas/Comments**

**Other Issues**

Other Issues

As an NASW member and social worker I am responding to the proposed notice on the Physician Fee Schedule and is requesting your assistance in sending additional comments to CMS about the proposed changes for clinical social workers. Comments are due August 21, 2006.Inform CMS how a 14 percent reimbursement cut will affect your practice and you as a Medicare provider;
Request CMS not to reduce work values for clinical social workers effective January 1, 2007;
Request CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and
Request CMS not to approve the proposed "bottom up" formula to calculate practice expense. Request CMS to select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

**Submitter :** **Dr. Diane Radford** **Date: 08/15/2006**

**Organization :** **St. Louis Cancer**

**Category :** **Physician**

**Issue Areas/Comments**

**Discussion of Comments- General, Colorectal and Vascular Surgery**

Discussion of Comments- General, Colorectal and Vascular Surgery

I write in support of Dr. Benjamin Anderson's letter dated August 3rd.
The peformance of lumpectomy should not be undervalued. To do so undermines our efforts to carry out breast preservation.

**Submitter :** Dr. Toyin Opesanmi **Date:** 08/15/2006

**Organization :** Park West Health Systems

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

It is the goal of every provider to provide excellent care to patients in order to ensure the best outcomes. It is not possible to achieve this goal without proper and adequate reimbursement in this time of high prices of all things. Increases in reimbursement will definitely help improve patient care.

**Submitter :** Dr. Donald McDonnell **Date:** 08/15/2006

**Organization :** Dr. Donald McDonnell

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1512-PN-1464-Attach-1.DOC

CMS-1512-PN
1164

Donald McDonnell, Ph.D.
62 Taft Avenue
Lexington, MA 02421-4133
August 8, 2006

Department of Health and Human Services
Attention: CMS-1512-PN
PO Box 8014
Baltimore, MD 21244-8014

To Whom It May Concern:

I am writing to oppose the proposed reduction in Medicare reimbursement to certain health and mental health providers. The proposal that Clinical Social workers receive a 7 percent reduction in work values and a 2 percent reduction in Practice Expense values effective January 1, 2007 would adversely effect the quality of care for some of our most vulnerable citizens. An additional proposed 5 percent decrease in Practice Expense values, proposed to occur by 2010, would eviscerate necessary care, and endanger patients.

A 14 percent reimbursement cut will adversely affect Clinical Social Work practice, and the quality of care provided.

I am requesting that CMS not reduce work values by 7 % for clinical social workers effective January 1, 2007.

I request CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers.

I request that CMS not approve the proposed "Top down" formula to calculate practice expense. I request they select a formula that does not create a negative impact for mental health providers.

Sincerely:

Donald McDonnell, Ph.D.

**Submitter :** **Ms. Fredda McDonnell** **Date: 08/15/2006**

**Organization :** **Ms. Fredda McDonnell**

**Category :** **Social Worker**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1512-PN-1465-Attach-1.PDF

AHCA
#1465

Fredda McDonnell, LICSW
5 Watson Road
Belmont, MA
August 15, 2006

Department of Health and Human Services
Attention: CMS-1512-PN
PO Box 8014
Baltimore, MD 21244-8014

To Whom It May Concern:

I am writing to oppose the proposed reduction in Medicare reimbursement to certain health and mental health providers. The proposal that Clinical Social workers receive a 7 percent reduction in work values and a 2 percent reduction in Practice Expense values effective January 1, 2007 would adversely effect the quality of care for some of our most vulnerable citizens. An additional proposed 5 percent decrease in Practice Expense values, proposed to occur by 2010, would eviscerate necessary care, and endanger patients.

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I request that CMS not approve the proposed "Top down" formula to calculate practice expense. I request they select a formula that does not create a negative impact for mental health providers.

Sincerely:

Fredda McDonnell, LICSW