Submitter : Mr. Greg Mahan **Date:** 08/10/2006

Organization : Peninsula Therapy Center, PLC

Category : Social Worker

Issue Areas/Comments

Background

Background

Medicare compensation is already lower than many other private insurance. Any lower and our practice would not be interested in being medicare providers. As Tricare payment is also contingent on Medicare provider status and we practice in a military area this would be detrimental to our clients. My practice is in a highly specialized treatment focus. This change could eliminate us as a treatment option. There are very few providers in the area with our specific area of expertise. The change will hurt military dependants as well as medicare enrollees

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Medicare compensation is already lower than many other private insurance. Any lower and our practice would not be interested in being medicare providers. As Tricare payment is also contingent on Medicare provider status and we practice in a military area this would be detrimental to our clients. My practice is in a highly specialized treatment focus. This change could eliminate us as a treatment option. There are very few providers in the area with our specific area of expertise. The change will hurt military dependants as well as medicare enrollees

Submitter : **Date: 08/10/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

Background

Background

I strongly support the proposed rule to increase the work relative value units assigned to Medicare Evaluation and Management codes, as recently proposed by the Centers for Medicare and Medicaid Services (CMS). As you know, family physicians provide essential services to many Medicare beneficiaries and the costs related to providing these services have increased significantly in the last 10 years. As a result, we have had to see a greater and greater number of patients per day, simply to keep our doors open, while many of us have seen our incomes decline as payments have not kept pace with the cost of providing services. Further, the care of our patients has become increasingly complex, as family physicians are often managing patients with multiple chronic diseases with co-morbidities, acting as care coordinators, and dedicating more time to helping our patients and their families.

Submitter : Dr. Raymond McCoy **Date:** 08/10/2006

Organization : Behavioral & Neuropsychiatric Group

Category : Social Worker

Issue Areas/Comments

Background

Background

The proposed 7% decrease in medicare fees for social workers would be devistating to our independent employment as Licensed Clinical Social Workers. We are, as a speciality, already the least paid and such a reduction would seriously impair our ability to continue to provide social work services in an out patient setting.

Submitter : **Dr. Ajay Batra** **Date: 08/10/2006**

Organization : **Milford Gastroenterology Associates, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1321-P-4-Attach-1.DOC

Submitter : **Ms. Frona Israel** **Date: 08/10/2006**

Organization : **Frona P Israel, MSW, BBA, Inc**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

I am totally against any fee reductions. We already suffered many fee reductions over the years. Social workers are on the front line every day for emergencies all the way down to family and individual counseling in the office and assisted living facilities. We speak to families, physicians, and attorneys already with no recourse for reinbursement. Please do not make our financial situation any more unbearable than it is already.

GENERAL

GENERAL

The cost of living continues to increase not decrease. The cost of gas is astronomical also to go the office, see patients in emergencies, and attend ongoing CEU requirements. We also have occupational licenses to pay for an malpractice insurance not to mention overhead with the office and billing expenses and trying to collect monies due from individuals and the insurance companies.

Impact

Impact

I would recommend that you reinstate the monies we used to recieve. Dont forget the cost of living goes up not down. We still have ongoing CEUs and requirements to meet financially and time wise.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am a Licensed Clinical Social Worker and have a Supervisor's License. I also hold 5 alchohol and drug abuse licenses including a supervisory license.

Submitter : Dr. Robert Hartung **Date:** 08/10/2006

Organization : Radiology Group Imaging Center, LLC

Category : Physician

Issue Areas/Comments

Background

Background

Continued cuts in payment for our referral-only Diagnostic Imaging Services threatens the future viability of outpatient imaging. We have already cancelled plans to upgrade our CT scanner based on the announced DRA provisions. Consideration of Digital Mammography, which has significant proven advantages, is questionable even though it's reimbursement is not affected by the DRA. Cuts in physician reimbursement that effectively subsidize the technical costs of mammography (mammography machines, film processors, film, storage, postage, transcrition, and MQSA record keeping requirements) may make mammography services less readily available or not available at all.

Impact

Impact

Decreased payment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The proposed rule decreasing payment for physician services based on the premise that physicians order more exams to receive additional pay fails in the case of Diagnostic Radiologists. We are prohibited from self-referral. Other physicians (non-Radiologists) can hire a licensed Radiologic Technologist and then install a CT and perform any CT examination in any quantity on their own patients. In the case of MRI most states do not require a licensed Radiologic Technologist to operate the machinery. Additionally, these non-Radiologist physicians have no training in Radiation Safety and in my experience perform more extensive examinations than are required presumably to collect the additional payments.

Additionally, as we provide services on a referral only basis we must make results (both written and images) available nearly immediately to continue to receive referrals. This is good medicine as the studies are available to any physician 24 hours a day and if the patient requires emergency room services, their studies can be reviewed prior to ordering additional exams or to add important comparative data to another exam. The self-referring non-Radiologists almost never install any sort of easily accessible archive and there are none that I know that provide web based access.

Submitter : Ms. Lisa Creef **Date:** 08/11/2006

Organization : Lisa B. Creef, L.C.S.W.

Category : Social Worker

Issue Areas/Comments

Background

Background

If Medicare goes forward with their proposed 14% cut in fees for social workers that will significantly effect my ability to keep my practice open. Overhead fees continue to rise and we cannot absorb cuts like that in collections.

GENERAL

GENERAL

Please do not approve the proposed Top down formula to calculate practice expense. It would be much more fair to select a formula that does not create a negative impact for those of us in the mental health field.

Impact

Impact

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

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Mrs. Gayle Edwards-Stegman **Date:** 08/11/2006

Organization : Harvest of HOpe Family Svc Inc

Category : Social Worker

Issue Areas/Comments

Background

Background

A reduction in the reimbursement to physicians and clincial social workers will discourage providers from becoming and/or continuing to be Medicaid providers. My agency had a provider number and dropped it because the reimbursement was so poor when the financial benefit/cost ratio is considered. Consumers who need services especially in the underserved rural areas are either denied services because there are no providers or the consumer must settle for the limited selection of Medicaid providers. In our rural area, consumers are limited to the community mental health centers that received an 'F' in their performance. Small practices have difficulty absorbing the cost/benefit ratio so are reluctant to become providers. Reducing the percentages of reimbursement further will only discourage the small and large providers limiting consumer access to well trained mental health professional providing quality services.

Submitter : Miss. Eleanor Hoenig **Date:** 08/11/2006

Organization : NASW

Category : Social Worker

Issue Areas/Comments

Background

Background

Mental Health providers have not gotten an increase in payments from any insurance company in years dispite the rise in the cost of living. This cut in payment policy will be another financial burden on my private practice and will cause me to rethink being a medicare provider

Provisions of the Proposed Rule

Provisions of the Proposed Rule

One of my patients is disabled due to obsessive compulsive disease. She worries constantly about making ends meet and will be greatly endangered by additional concerns should therapy no longer be a support for her. She has no money to make any additional payments or co--payments. She is but one of many such people covered by the program.

Submitter : Mr. John Bennett **Date:** 08/11/2006

Organization : Mr. John Bennett

Category : Social Worker

Issue Areas/Comments

Background

Background

The proposed 14% decrease in funding for non-physician providers will make it fiscally unlikely that I will continue to be able to provide clinical social work services to many seniors, including psychosocial evaluation and psychotherapy. Many clinical social workers, such as myself, already waive our low income senior patient's copayments. With a reduction in reimbursement many pracitioners will have to drop these client's cases. Among these seniors are often the most lonely and isolated, precisely the ones most in need of our professional treatment services.

Submitter : **Paulette Massari** **Date: 08/11/2006**

Organization : **Paulette Massari**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

If the proposed 14% decrease in payments pass, many of my patients will not be able to access my services nor the services of many other clinicians.

Submitter : JANE SEFF **Date:** 08/11/2006

Organization : JANE SEFF

Category : Social Worker

Issue Areas/Comments

Background

Background

NASW informs that Medicare rates for non-physician providers will be cut 14%, inorder to pay physicians more. This will adversely affect my ability to service Medicare patients in need of psychotherapeutic help.

Submitter : **Ms. Rebecca Morales** **Date: 08/11/2006**

Organization : **Private Practitioner**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

Many of my elderly patients are isolated with physical impairments. They're unable to seek traditional forms of psychotherapy so I come to them. Often I'm one of the few, if not the only face they see during the week. With increased gas prices and decreased medicare rates it would be impossible for me to continue my practice. Please reconsider this proposal

Impact

Impact

Please withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all medicare providers.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

social work LCSW-R

Submitter : Mr. Gregory Carson **Date:** 08/11/2006

Organization : Private Practice

Category : Social Worker

Issue Areas/Comments

Background

Background

I feel that the impact of tis will be extrememtly negative. As it is I can only see so many medicare patients in my practice becasue the reimbursement is low compared to private paying patients. But I am effective in my specailization. If the rate is lowered, medicare patients will have less choices as quality providers will not offer their services. In the long run, patients will utilize more long-term care becuase the care available will be of a lower standard and will be less effective.

GENERAL

GENERAL

I feel that the impact of tis will be extrememtly negative. As it is I can only see so many medicare patients in my practice becasue the reimbursement is low compared to private paying patients. But I am effective in my specailization. If the rate is lowered, medicare patients will have less choices as quality providers will not offer their services. In the long run, patients will utilize more long-term care becuase the care available will be of a lower standard and will be less effective.

Submitter : Myrna Moran **Date:** 08/12/2006

Organization : National Association of Social Workers

Category : Social Worker

Issue Areas/Comments

Background

Background

A reduction of Medicare payments would adversely affect my private practice as a psychotherapist, such that I would have to work even longer hours to make the same amount of money. Would you like to have a tired psychotherapist who is annoyed with your health insurance provider?

GENERAL

GENERAL

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 : **Dr. William Hass** **Date: 08/12/2006**

Organization : **AAH, LLC**

Category : **Physician**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

12 August 06

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

Re: Proposed Changes to Anesthesiology Fee Schedule for CMS services

Sir,

In your considerations of the above captioned fee schedule change, please consider what I have learned in almost 30 years of anesthesia practice. The anesthesia services in the US are most commonly provided by group practices that consist of anesthesiologists, certified registered nurse anesthetists (CRNAs), anesthesiologists assistants (AAs), and other advanced practice nurses (APN). The services provided by a contemporary anesthesia group extend far beyond simple putting people to sleep and now include preparing patients for surgery, acute post-operative pain management, intensive care services, OB analgesia services, sedation for complex procedures outside the operating room, and chronic pain management. In each of these endeavors an anesthesia group improves safety and outcome as well as reduces costs. In my current group for every two operating room anesthetics done, we provide another valuable clinical service, usually uncompensated, to all the hospital s patients. I believe this 2:1 ratio holds true for many practices.

Beyond the clinical staff, each anesthesia group has a cadre of support specialist involved in scheduling, compliance, and billing personnel. Office space is rented and benefits are paid. Lawyers, and accountants are employed. A typical anesthesia group has impressive overhead costs. The vision of the anesthesiologist as having little or no practice overhead or perioperative role is not correct for the majority of anesthesiologists today. Any studies that suggest otherwise are suspect. If your data suggests that most anesthesia group has low overhead, perhaps a comprehensive survey across specialties needs to be done.

CMS has made several decisions that have had an adverse impact on the practice of anesthesia. We are penalized for training our future anesthesiologists and CRNAs. The impact of technology in our specialty is not recognized. The needs of patients seem to have a low priority. I hope that CMS s lack of insight in contemporary anesthesia practice will be improved by meeting with the leaders of our professional societies and in this case by gathering current data on overhead expenses.

Despite the above comments, I appreciate your efforts to provide the best healthcare to our citizens. Your decisions are important to both provider and patient.

Sincerely,

William H. Hass, MD, MBA
Director of Anesthesiology
Crestwood Medical Center
Huntsville, AL 35801
whhass@earthlink.net

Submitter : Mr. Ryan Sanft **Date:** 08/13/2006

Organization : NASW

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I disagree with the proposed changes. A 14 percent reimbursement cut will affect my practice and me as a Medicare provider;
I request CMS not to reduce work values 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; and
I request CMS not to approve the proposed "bottom up" formula to calculate practice expense. Instead I 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. debbie popielarczyk **Date:** 08/13/2006

Organization : APTA

Category : Physical Therapist

Issue Areas/Comments

Background

Background

Proposed cuts to Medicare pose a severe threat to physical therapists ability to provide care for Medicare beneficiaries. Patients may not have access to care and may go with out appropriate treatment.

GENERAL

GENERAL

The Centers for Medicare and Medicaid Services (CMS) is proposing to reduce the relative work values for services provided by physical therapists and other professionals who bill Medicare under the physician fee schedule. If implemented as proposed, these work value reductions would cut payment to physical therapists by 6% in 2007 and when combined with other adjustments could result in aggregate cuts of nearly 10%. These cuts pose a severe threat to physical therapists ability to provide care for Medicare beneficiaries. I strongly opposed this system.

Submitter : Dr. Henry Walther **Date:** 08/13/2006

Organization : Central Anesthesia Service Exchange Med. Grp

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

August 14, 2006
To Whom It May Concern,

As an anesthesiologist with twenty years of practice experience, I must protest the egregious payment cuts proposed for my specialty under the current CMS practice expense methodology. These would require an immediate 5% cut, followed by annual 1% per annum cuts to a total of 10% by 2010.

As a citizen, I must state:

" Anesthesiologists are already in significant shortage and this shortage is projected to worsen dramatically in the next two decades.

" The entire concept of reducing payments for ANY NECESSARY service that is already in undersupply (and worsening in the projected decades) flies in the face of economics, common sense, and the realities of the marketplace.

" Since 1990, the U.S. Bureau of Economic Analysis reports a 110% increase in compensation to our 1.9 million federal employees. In this time, MediCare reimbursement per anesthesia unit has been cut by more then 50%, before adjustment for inflation. In real terms, a unit of anesthesia care now pays about 30% of its 1990 value. This discrepancy between expansion of federal salaries and payment to indentured physicians (Medicare is legally mandated) exposes an amazing degree of self-dealing .

As an anesthesiologist, I must state that:

" 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 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.

When I interact with young people who are considering career paths, I never spontaneously encourage them to enter the medical field. I believe any student possessing the intellect and ambition my generation of physicians had would find greater autonomy, less bureaucracy, and far better life balance, in other areas of endeavor. I am,

Henry C. Walther, MD
Granite Bay, CA. 95746

Submitter : Dr. david wexler **Date:** 08/14/2006

Organization : Dr. david wexler

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
7500 Security Boulevard
Baltimore, MD 21244 8014

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

Dear Doctor McClellan:

I am a practicing gastroenterologist in Clark, NJ and have been a Medicare participating provider since 1985. Thank you for the opportunity to comment regarding the proposed changes to the Physician Fee Schedule for 2007.

I am pleased that CMS has agreed with the recommendations of the RUC, as part of the five-year review process, to maintain the current work values for the following procedures commonly performed by gastroenterologists: 43235 (esophagogastroduodenoscopy); 43246 (upper gastrointestinal endoscopy, with directed placement of percutaneous gastronomy tube); 45330 (flexible sigmoidoscopy) and 45378 (colonoscopy). I support the recommendation to implement these work values in the 2007 final rule.

I am also supportive of the increases proposed to the physician work values for the evaluation and management codes. However, I am concerned about the constraints caused by budget neutrality and a flawed sustainable growth rate formula, and hope that Congress can allocate additional money to prevent cuts in reimbursement for other services. Given that our practice overhead continues to increase, and employees are dealing with higher commuting costs, it is unconscionable for CMS to recommend a reduction in fees when Medicare payments fail to cover our costs for providing services to Medicare beneficiaries. In addition, we have had a payment freeze or slight increase in Medicare payments for the past several years.

In the Proposed Rule, CMS is proposing to change the practice expense methodology and incorporate the supplemental practice data for gastroenterology and several other specialties. Unfortunately, CMS did not implement this data in 2006 after its acceptance in the 2006 Proposed Rule. I request that CMS implement this supplemental practice expense data in the Final Rule for 2007 and future years.

I am extremely concerned about the projected 5.1% cut to the conversion factor for 2007. This will have a serious and adverse impact to my practice, and will negatively impact beneficiary access to medical care. I hope that CMS will work with Congress to avert this payment cut for 2007, and work to provide a permanent solution remedying the flawed sustainable growth rate (SGR) formula. I support the recommendation that CMS should remove expenditures for drugs from the SGR formula on a retrospective basis, and rectify this situation as soon as possible.

Thank you for your consideration of my comments.

Sincerely,

David E. Wexler, MD

Submitter : **Ms. Audrey Bennett** **Date: 08/14/2006**

Organization : **individual**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

I am writing in opposition of the proposed physician fee schedule changes which will decrease fee reimbursement to social workers by at least 14%. I am in opposition to this for several reasons. First because there is also a proposal to increase evaluation and management codes, actually there is a need to increase reimbursement for all Medicare providers. Secondly, Medicare reimbursement is limited as it is. There are a limited number of providers especially in Social Work. To decrease reimbursement, would be to further limit potential social workers who could become providers and move those who already are providers, to drop Medicare from their provider list since it is an extensive proceedure for reimbursement and becoming a liability to private practice. Please do not approve the 'bottom up' formula to calculate practice expense. The bottom rung, as social workers have very little practice expense in comparison to physician and other medical providers.

Respectfully,

Audrey Bennett, LCSW, LADC.

GENERAL

GENERAL

I obtained my LCSW this year and have initiated becoming a Medicare provider under a private practice. It is very discouraging to see clients turned away from services because there are already not enough social workers on the provider list. Social Workers are trained professionals who provide specialized services which are greatlt needed. Fee reduction in our service area stifles provision of services and the clients will suffer the most.

Impact

Impact

Develop a system fee reduction based upon the over all number of dollars spent . The greatest expense codes would be reduced the most. This would balace the spending reductions over all rather than pick and choose. The whole spectrum of provider fees would be decreased in porportion to their system needs.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

9 years in Social Service provision. LCSW, Licensed Alcohol and Drug Counselor.

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

Organization : East Central Counseling

Category : Health Care Industry

Issue Areas/Comments

Background

Background

It is unfortunate that the Gov't is reducing reimbursement for Medicare to Social Workers. I have been in private practice for 25 years and cannot afford to see Medicare patients, so I have referred them elsewhere for 25 years. This reduction in reimbursement supports my decision never to enter the Medicare System. I dread the day when Medicare becomes my only healthcare insurance.

GENERAL

GENERAL

above in 'Impact"

Submitter : Mr. Edward Aribisala **Date:** 08/14/2006

Organization : SOUTHWESTERN VERMONT REGIONAL CANCER CENTER

Category : Physician

Issue Areas/Comments

Background

Background

Without the reimbursement, some patients who need the service will not seek it for financial reasons and this leads to poor prognosis and cachexia (a general wasting of the body muscle tone and shape due to a chronic illness) with the body not having enough nutrients to help recovery from the cancer or opportunistic infections.
*Dietary Counseling Improves Patient Outcomes: A Prospective, Randomized, Controlled Trial in &
P Ravasco, I Monteiro-Grillo, PM Vidal, ME Camilo - Journal of Clinical Oncology, 2005 - jco.org

GENERAL

GENERAL

NEW STEPS TO INCREASE VALUE IN HOSPITAL OUTPATIENT CARE, WITH MAJOR REVISION OF AMBULATORY SURGICAL CENTERS PAYMENTS
Below is the comment about the proposed rule about payment for Nutritional Counseling for Cancer Patients for your serious consideration:
ISSUE:
Securing Medicare reimbursement for nutritional counseling for cancer patients.
Description of the issue:
Medicare reimbursement for nutritional counseling for cancer patients should be enacted or provided for by the government.
Its negative implications/why it should be changed:
Without the reimbursement, some patients who need the service will not seek it for financial reasons and this leads to poor prognosis and cachexia (a general wasting of the body muscle tone and shape due to a chronic illness) with the body not having enough nutrients to help recovery from the cancer or opportunistic infections.

Impact

Impact

Medicare reimbursement for nutritional counseling for cancer patients should be enacted or provided for by the government.
By our representatives in Washington adding cancer to the list of diseases like, diabetes, renal and bariatric indications, for coverage. My legislator,Senator Leahy's office promised to bring the issue up in the last session, but unfortunately it did not make it to the level of attention I believe it warranted,please allow payment for Nutritional Counselling for cancer patients under the Medicare coverage

Provisions of the Proposed Rule

Provisions of the Proposed Rule

*Dietary Counseling Improves Patient Outcomes: A Prospective, Randomized, Controlled Trial in &
P Ravasco, I Monteiro-Grillo, PM Vidal, ME Camilo - Journal of Clinical Oncology, 2005 - jco.org
CONCLUSION: During radiotherapy, both interventions positively influenced outcomes; dietary counseling was of similar or higher benefit, whereas even 3 months after RT [sic Radiotherapy], it was the only method to sustain a significant impact on patient outcomes.

CMS-1321-P-23-Attach-1.DOC

Attach #
23

Dear Sir/Madam;

Re: NEW STEPS TO INCREASE VALUE IN HOSPITAL OUTPATIENT CARE, WITH MAJOR REVISION OF AMBULATORY SURGICAL CENTERS PAYMENTS: CMS1321P

Below is the comment about the proposed rule about payment for Nutritional Counseling for Cancer Patients for your serious consideration:

ISSUE:

Securing Medicare reimbursement for nutritional counseling for cancer patients.

Description of the issue:

Medicare reimbursement for nutritional counseling for cancer patients should be enacted or provided for by the government.

Its negative implications/why it should be changed:

Without the reimbursement, some patients who need the service will not seek it for financial reasons and this leads to poor prognosis and cachexia (a general wasting of the body muscle tone and shape due to a chronic illness) with the body not having enough nutrients to help recovery from the cancer or opportunistic infections.

*Dietary Counseling Improves Patient Outcomes: A Prospective, Randomized, Controlled Trial in ...
P Ravasco, I Monteiro Grillo, PM Vidal, ME Camilo - Journal of Clinical Oncology, 2005 - jco.org

CONCLUSION: During radiotherapy, both interventions positively influenced outcomes; dietary counseling was of similar or higher benefit, whereas even 3 months after RT [sic Radiotherapy], it was the only method to sustain a significant impact on patient outcomes. According to the Lombardi Cancer Center in Washington DC, some of the advantages of nutritional counseling includes, but not limited to:

-Healthy eating during chemotherapy and /or radiotherapy.

- Appropriate calorie estimations and enteral /parenteral nutrition assessment/ treatment

-Nutritional requirements during various cancer

-Food preparation and food safety: neutropenic guidelines.

-Food aversions and what to do to overcome these side effects from treatment regimens.

-Ways to improve the cancer patient's immune system through diet.

-Vitamin and mineral supplements: what dosages to take, how often and if necessary.

-Nutrition and its relationship to other cancer prevention.

-Which references provide sound information regarding nutrition and cancer.

-Alternative nutrition and media fads.

How we want it changed/ suggestion for what to change it to:
By our representatives in Washington adding cancer to the list of diseases like, diabetes, renal and bariatric indications, for coverage. Senator Leahy's office promised to bring the issue up in the last session, but unfortunately it did not make it to the level of attention I believe it warranted, please allow payment for Nutritional Counseling for cancer patients under the Medicare coverage.

Why it is important to take the action you advocate:
Better patient care and clinical outcome as a result of nutritional counseling and attention; a shift in patients' paradigm.

I will be available if more information is needed or if you need me to testify in respect to this issue.

Respectfully yours,

Teddy Aribisala RTT,MSc[Eng], MBA,ACHE
Administrator Cancer Services
802-447-1836 [Phn]
802-440-4260...new number
802-440-6097 [Fax]
arie@phin.org
Southwestern Vermont Regional Cancer Center [SVHC]
140 Hospital Drive Suite 116
Bennington, Vermont. 05201
Website www.svhealthcare.org

Submitter : Ms. Ninah Kessler **Date:** 08/14/2006

Organization : Ms. Ninah Kessler

Category : Social Worker

Issue Areas/Comments

Background

Background

Social Workers are paid so little for seeing medicare patients that a decrease in the payment scale would threaten provision of mental health services to patients. This would put patients at risk for decreased physical health, which would drive up medicare costs.

Submitter : Ms. Anne Shields **Date:** 08/14/2006

Organization : NASW

Category : Social Worker

Issue Areas/Comments

Background

Background

Although I don't have Medicare clients as a majority of my caseload, I do have at least 20% at all times, so a reduction in fees would significantly impact me. As the population ages, more Medicare clients will be needing services and social workers are well trained to provide what the geriatric members of our society will need.

Impact

Impact

Please do not reduce the work values by 7% for clinical social workers effective Jan. 1, 2007.
Please withdraw the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Mdeicare providers.
Please do not approve the proposed "top down" formula to calculate practice expense . Please select a formula that does not create a negative impact for nental health providers.

Submitter : Dr. Seabury Davies **Date:** 08/15/2006

Organization : Mountain West Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Anesthesiologists already suffer from a substantially depressed Medicare fee schedule as compared with their physician cohorts. This persists despite evidence that Anesthesiologists continue to lead efforts in improving patient safety and developing evidence based medicine protocols. Not only is a budget neutral approach to Medicare physician reimbursement impractical and inappropriate but really downright irresponsible. Medicare simply cannot sustain itself unless the revenue side of the equation is addressed. It is time for us to all address the politically unpalatable reality of increasing premiums or copays. Medicare was never designed to function as it does in the modern environment and it cannot survive without modification. Health care consumers in all other insured markets pay more for the dramatically increased costs of care. Why not Medicare? Don't pick on the providers especially Anesthesiologists,WE ARE PATIENT ADVOCATES AND YOUR PARTNERS.

Submitter : Mr. Javier Matos **Date:** 08/15/2006

Organization : Uniting Hands Counseling Services,PC

Category : Social Worker

Issue Areas/Comments

Background

Background

Devastating! my practice has an increased number of senior citizens who already are experiencing cuts in all their other areas of their lives..... As a social worker sometimes i don't charge them copayment fees because they have a very limited budget but at same time is not allowing to keep my door open for them due to increase maintanance and rent as well as utilities.

Impact

Impact

I oppose the 14% cut. This will affect my practice tremendously.
I am requesting CMS not to reduce work values for my clinical work services effective janurary 1, 2007.
I am requesting CMS to withdraw the proposed increased in evaluation and management codes until you have the funds to increase reimbursement for all medicare providers.
I also request CMS not to approve the the proposed "bottom up" formula to calculate practice expense.
I am requesting CMS to select a formula that does not cerate a negative impact for clinical social workers who have very little practice expense as providers..

Submitter : Mr. Vincent Rubino **Date:** 08/15/2006

Organization : V.J.Rubino, LCSW, LSCSW

Category : Social Worker

Issue Areas/Comments

Background

Background

A 14 percent reimbursement cut will REDUCE THE NUMBER OF MEDICARE PATIENTS that can be followed for treatment by 35% to offset the loss in revenue.

As a medicare provider, I receive reinbursment at a 19% lower rate than is paid by other third party payors. Reducing this rate by another 7% or 15% will make it too cost ineffective to continue serving the current number of medicare patients that are in treatment within the practice.

Further more, please withdraw the proposed increase in evaluation and management codes until funds to increase reimbursement for all Medicare providers are available. This and a reduction the rate of reinbursment will force many of the independent providers out of business.

Please do not approve the proposed "Top down" formula to calculate practice expense. This formula creates a negative impact on mental health providers which will threaten our ability to stay in business.

GENERAL

GENERAL

As a medicare provider, I receive reinbursment at a 22% lower rate than is paid by other third party payors. Reducing this rate by another 7% or 15% will make it too cost ineffective to continue serving at least 35% of the current number of medicare patients that are in treatment within the practice.

Please do not reduce work values by 7% for clinical social workers effective January 1, 2007. Thia will have a significantly negative impact on our ability to stay in business.

Further more, please withdraw the proposed increase in evaluation and management codes until funds to increase reimbursement for all Medicare providers are available.

Please do not approve the proposed "Top down" formula to calculate practice expense. This formula creates a negative impact on mental health providers.

Submitter : Dr. harry collins **Date:** 08/15/2006

Organization : Dr. harry collins

Category : Physician

Issue Areas/Comments

Background

Background

The proposed Medicare Cuts will have a devistating impact on my geriatric practice. I am a geriatric board certified family physician and hospice physician.In on order to keep current and best serve my patients, I sat for geriatric certification 1n 1988 and recertificatios in 1997 and2006.Each exam reqiuired well over 100 hours of studying. All this effort will be in vain if I can no longer stay in practice as my costs continue to rise and my fees go down. I consider myself agovernment worker since 50% of my income comes from Medicare.I think if physician cuts are 5% next year, all government wokers should enjoy a similar decrease.I have been in practice over 25 years.
Many physicians will be forced to retire early or be required to spend
less time with patients who require a lot of time.
It is certainly true that technology and medications have caused
the cost of medical care to soar. Our goal as geriatricians is to provide good cost effective medicine. Our fees for seeing patients
for health maintance and contol of diseases is NOT the reason
costs have risen.
please consider not decreasing our reimbursements.

Submitter : Mrs. Sylvia Pleasant **Date:** 08/16/2006

Organization : Andrus & Associates Dermatology, PA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

The proposed 5.1% pay cut (7% estimate for dermatology), which is being compared to 2001 reimbursement levels, will not allow us to meet inflated expenses while continuing to serve increasing volume of Medicare patients. We prefer to continue acceptance of all Medicare patients, but will likely have to limit service to existing patients.

I believe the patients would be willing to share the increases of costs to the MC program by increased coinsurance for outpatient office care rather than experiencing decreased accessibility to the best physicians.

We represent small practices, 2 providers, therefore with decreasing reimbursement we cannot budget for EMR. However, proposal for financial assistance for e-prescribing/EMR is encouraging.

Physicians and other healthcare organizations cannot be expected to sustain the program by continued reimbursement reduction. By nature, "the physician" desires to care for the patient at all cost, but based on management of outpatient offices for 35 year, I believe such proposed cuts will result in limited accessibility by practices non-participating or limiting visits for Medicare patients. I believe some of the best senior physicians will choose to retire. Physicians have continued to sacrifice revenue for the last few years because of compromised reductions. I think this will be the "straw that broke the camel's back".

Submitter : Mrs. Joanne Maly **Date:** 08/16/2006

Organization : Fitness Forum Physical Therapy

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

I am strongly opposed to the proposed CMS reduction in fee schedule to physical therapist and other professionals. THis would strongly effect our ability to provide care to Medicare patients.
Please consider this opposition in your decision.
Joanne Maly, PT, Cert MDT, CSCS

Submitter : **Alan Finston** **Date: 08/16/2006**

Organization : **Alan Finston**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

I wish to coment on the June 29 proposed notice that sets forth proposed revisions to work value units and revises the methodology for calculating practie expense RVU's under the Medcicare physician fee schedule. I am a physical therapist in private practice in a small community. My services are vital to the older people in my town.

GENERAL

GENERAL

These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves a greater quality of care. If payment for these services is cut so sevely, access to care for millions of the elderlyl and disabled will be jeopardized. CMS emphasizes the importance of incrasing payment for E/M services to allow physicians to manage illnesses more effectivley and therefore result in better outcomes. Increasing paymnet for E/M services is important - but the value of services provided by all Medicre providers should be acknowldeged under this payment policy. Physical therapists spend a considerable amount of time in face-to-face consultation and treatment with patients, yet their services are being reduced in value.

Thank you for allowing me to comment and for consideration of my comments.

Sincerely,

Alan Finston, PT OCS
Whatcom PT and Fitness
Blaine, WA 98230
360-332-8167

Impact

Impact

I urge that CMS ensure that Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. I recommend that CMS transition the changes to the work relative value units (RVU's) over a four year period to ensure that patients continue to have access to valuable heatlhc are services.

Submitter : **Ms. Carrie Hall** **Date: 08/16/2006**

Organization : **Movement Systems Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

The Centers for Medicare and Medicaid Services (CMS) is proposing to reduce the relative work values for services provided by physical therapists and other professionals who bill Medicare under the physician fee schedule. If implemented as proposed, these work value reductions would cut payment to physical therapists by 6% in 2007 - and when combined with other adjustments could result in aggregate cuts of nearly 10%. These cuts pose a severe threat to physical therapists' ability to provide care for Medicare beneficiaries.

GENERAL

GENERAL

Physical Therapists spend a considerable amount of time in face to face consultation and treatment with patients, yet our services are being reduced in value. These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment of these services are cut so severely, access to care for millions of the elderly and disabled will be jeapordized.

Impact

Impact

I recommend that CMS transition the changes to RVU's over a 4 year period to ensure that patients continue to have access to valuable health care services. I urge CMS to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007.

Submitter : Dr. kevin wheelan **Date:** 08/16/2006

Organization : Baylor University Medical Center

Category : Physician

Issue Areas/Comments

Background

Background

The proposed changes will force our practice (72) cardiologists in the DFW area to limit services which we offer medicare patients. We will not be able to afford offering telephone medication refills and will need to limit the total number of medicare patients that we see each day so that available visits can be filled by patients on whom we do not loose money.

GENERAL

GENERAL

I am 50 years old and at the peak of my career.

Impact

Impact

The reductions in physician compensation are so unrealistic that the entire structure of US healthcare will be threatened. Every other profession is getting inflation adjustments in compensation. It is incomprehensible to think that doctors should bear the entire burden of rising costs. No insurance company executives or drug company employees are being asked to reduce their pay. The medical profession will not be able to attract talented people with this proposal

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The SRG method is totally flawed for the current economic environment and needs to be redone.

Submitter : **Jeff Drawbond** **Date: 08/16/2006**

Organization : **McFarland Clinic**

Category : **Physician**

Issue Areas/Comments

Background

Background

You are destroying anesthesia education in the USA. Without anesthesia you will not have surgery. Please reverse your insane teaching rule now!

Submitter : Ms. Barbara Hamann **Date:** 08/17/2006

Organization : Ms. Barbara Hamann

Category : Social Worker

Issue Areas/Comments

Background

Background

Since the early 1990's my profession has been attacked in our pocketbooks by organizations conspiring to reduce our fees. Many of my colleagues have been forced out of business and I now prefer to do work for the courts, payment for which allows me to barely maintain a middle class existance. If I were younger I would have changed professions and I discourage anyone from going into social work. The schools of social work get students by telling them of the many available jobs. They neglect to tell them the reasons for all these jobs is that none of them pay a reasonable salary, commensurate with the education and training necessary to obtain a license. The public agencies pay and treat these professionally trained people like factory workers. Cutting compensations further will only worsen the extreme shortage of this service, which will be our society's loss. Already, the wealthy can access services and the poor are left with little or nothing.

Submitter : Mr. Lloyd Fray **Date:** 08/17/2006

Organization : Victoria Radiology Associates

Category : Radiologist

Issue Areas/Comments

GENERAL

GENERAL

"SEE ATTACHMENT"

CMS-1321-P-37-Attach-1.DOC

Attach #
37

VICTORIA RADIOLOGY ASSOCIATES
A TEXAS PROFESSIONAL ASSOCIATION

James F. Neumann, M.D., D.A.B.R.
Frank P. Wilson, Jr., D.O., D.A.B.R. ±
±*Certified American Board of Pediatrics*
Stephen W. Tibbitts, M.D., D.A.B.R.

Steven C. Schnicker, M.D., D.A.B.R.*
**Board Certified Nuclear Cardiology*
D. Bruce Tharp, M.D., D.A.B.R.
Ronald K. McCauley, M.D., D.A.B.R., F.A.C.N.M.

August 17, 2006

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

Victoria Radiology Associates Recommends 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." All of our CAD technical is analog and will continue to be for some time.

"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 as required by statute." There have been no changes to substantiate this proposed rule for the use of CAD with analog mammography.

Sincerely,

Lloyd L. Fray
Business Manager

Submitter : Dr. W. Stephen Minore **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

Background

Background

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

GENERAL

GENERAL

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 AMS are commited 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 of 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 : Dr. Maria Laporta **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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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 AMS 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 of our nation s most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Dr. Norbert Duttlinger **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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

Submitter : Dr. John Shiro **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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

Submitter : Dr. Douglas Loughead **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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Submitter : Dr. Vincent Quinlan **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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

39-6

Submitter : Dr. Steven Gunderson **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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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 AMS 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 of our nation s most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Provisions of the Proposed Rule

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Submitter : Dr. John Szewczyk **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Provisions of the Proposed Rule

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Submitter : Dr. Timothy Starck **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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Submitter : Dr. Edward Post **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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

Submitter : Dr. George Arends **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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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 AMS 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 of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Dr. Bryan Apple **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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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 AMS 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 of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Dr. Mark Cirella **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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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 AMS 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 of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Dr. David DesertSpring **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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

Submitter : Dr. Dean Enser **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Provisions of the Proposed Rule

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

Submitter : Dr. Sammy Farag **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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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 AMS 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 of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

39-16

Submitter : Dr. Rao Gondi **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Provisions of the Proposed Rule

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

39-17

Submitter : Dr. Steven Hryszczuk **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Dr. John Jaworowicz **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Dr. Joe Juarez **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : Dr. John Kallich **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Provisions of the Proposed Rule

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

Submitter : Dr. Myung-Sang Lee **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 AMS 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 of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Submitter : **Date: 08/18/2006**

Organization : **Miami Cardiopulmonary Institute, LLC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1321-P-60-Attach-1.WPD

CMS-1321-P-60-Attach-2.DOC

Attach # 60

MIAMI CARDIOPULMONARY INSTITUTE, LLC
3200 Ponce de Leon Blvd.
Coral Gables, FL 33134
JCAHO Accredited

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (June 29, 2006); Comments re: Practice Expense

Dear Mr. McClellan:

On behalf of Miami Cardiopulmonary Institute and our nine individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

Miami Cardiopulmonary Institute (MCPI) is an Independent Diagnostic Testing Facility with nine medical staff members. As an outpatient facility, MCPI abides by the selection criteria initially set up by CMS and incorporates all of the policy and procedures to Joint Commission standards. Quality Assurance Indicators and thresholds are based on the ACC and benchmarked with other outpatient cardiac cath labs. The average yearly outpatient cardiac catheterization volume at MCPI is 620.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact of the proposed methodology on procedures with significant TC costs because they share the same problems that we will outline below. We also believe that the same solution should be applied to all of the procedures listed below.

With regard to catheterizations, the proposed change in PE RVUs would result in a 53.1 percent reduction of payments for CPT 93510 TC. Similarly, payment for two related codes—93555 TC and 93556 TC would be reduced substantially. In fact, under the Medicare Physician Fee Schedule ("PFS"), payment for these three codes would fall from 94 percent of the proposed

2007 APC rate for these three codes to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	Description
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom up micro-costing approach is laudable and consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comport with the statutory requirement that would match resources to payments. After reviewing the proposed methodology, including the 19 step calculation, we have identified several flaws that result in the PE RVU underestimating the resources needed to provide the technical component of cardiac catheterizations. We will address our concerns with the calculation of direct costs and indirect costs separately, as set forth below.

Direct Costs

The estimate of direct costs is critical for the first step in calculating the PE RVU for each procedure code. The direct costs are based on inputs from the American Medical Association's RVS Update Committee ("RUC") and reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. The RUC-determined direct costs do not reflect estimates of additional labor, supply and equipment costs that were submitted by (The Society for Cardiovascular Angiography and Interventions ("SCAI") or an industry group). As a result, the RUC-determined cost estimate is about half of the estimate that would result if all of the data were included. The addition of these additional costs which are consistent with the RUC protocol would increase the proposed PE RVUs by 24 percent.

Even if the RUC estimates included the additional costs submitted by SCAI or an industry group, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns. For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients. Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

Unless the RUC considers the actual costs of the clinical labor, supply and equipment used to perform a cardiac catheterization, the PE RVU that results at the end of the 19 step calculation will never reflect the actual resources needed to perform the procedure and will result in destabilizing practice expense payments to physicians. Therefore, CMS must evaluate the adequacy of the direct inputs and focus on developing a methodology that captures the average direct costs of performing a procedure, rather than the direct costs of performing a procedure that represents 51 percent of the patients.

A new methodology is needed based on the best data available so that the direct costs shown in the third column of the table below can be allocated in a manner similar to the allocation of indirect costs. This would result in a PE RVU that is a more accurate reflection of the direct and indirect costs for the resources that are critical to performing the procedure.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC–Determined Estimates

Direct Cost Category	***Included In RUC–Determined Estimate***	***Excluded From RUC–Determined Estimate***
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
Medical Supplies	• Supplies Used For More Than 51% of Patients	• Supplies Used For Less Than 51% of Patients
Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. There are additional improvements that can be made in the manner by which the indirect costs are estimated that are outlined below.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties – Independent Diagnostic Treatment Facilities ("IDTFs"), which account for about two-thirds of the utilization estimate for 93510 TC, and cardiology. The IDTF survey includes a wide range of facilities, but do not reflect the cost profile of cardiac catheterization facilities--that may have a cost profile similar to cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both (1) the direct costs at the procedure level, and (2) the indirect costs at the practice level.

Solutions

We believe that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization procedures and CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool ("NPWP") has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterization performed in practice or IDTF locations. The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. As a result, we request that CMS freeze payment for these cardiac catheterization-related procedure codes for one year to allow time for a complete assessment of the cost profile of the services listed in the chart provided above.

We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted to CMS to supplement these comments either separately or as part of our comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007. It is our understanding that CMS will accept additional data that helps CMS in evaluating the impact of the PE RVU methodology on our practices.

Sincerely,

Veronica Gonzalez, Director
Miami Cardiopulmonary Institute, LLC

Submitter : Dr. Bruce Murphy **Date:** 08/18/2006

Organization : Little Rock Cardiology Clinic, P.A.

Category : Physician

Issue Areas/Comments

Background

Background

Our consultative cardiology practice operates our own outpatient cardiac cath lab as part of our clinic. Since 65% of our patients are covered by Medicare, the draconian cuts proposed for the 2007 Part B fee schedule would most certainly force us to close our lab. The result would be a loss of an important access point for our patients and substantial financial loss for our practice.

GENERAL

GENERAL

See Attachment.

CMS-1321-P-61-Attach-1.DOC

Attachment 61

August 18, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (June 29, 2006); Comments re: Practice Expense

Dear Dr. McClellan:

On behalf of Little Rock Cardiology Clinic, P. A. (LRCC) and our 14 individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practice.

LRCC operates its own cardiac catheterization laboratory as part of a comprehensive outpatient cardiovascular diagnostic and treatment center in Central Arkansas. The ability to provide as much diagnostic capability as reasonably possible in one place is very important for our patients in this market. For the convenience of our mostly elderly patients, LRCC cardiologists regularly see patients in 28 outreach clinics across the State in mostly rural communities. When more advanced diagnostic tests are needed, theses same patients often drive two hours or more to our office in Little Rock to receive these services. We work very hard to provide as much care as we can in one visit to minimize the travel required by our patients. Operating our own cath lab has been a great help in providing these services in a coordinated and efficient fashion. If the fee cuts currently proposed by CMS are implemented, LRCC will, without a doubt, have to close its cath lab and a highly coordinated provision of care for the convenience of mostly Medicare covered patients will be lost. It will not be possible to duplicate

the same level of coordination if patients can only receive this important diagnostic test in a local hospital.

There is one other aspect of this proposed fee change that CMS must consider. The provision of high quality and accessible care to Medicare beneficiaries requires a long-term partnership between the Federal government and a broad range of providers of care. This partnership requires that the providers of care are able to make investments in diagnostic and treatment capability with an expectation that the economic assumptions of those investment decisions will be at least somewhat stable over a reasonable period of time. I think you would agree that cutting payments by more than 50% in one year for outpatient cath labs is inconsistent with CMS being seen as a good and reliable partner in providing access to care for Medicare beneficiaries. This proposed cut will definitely mean the closure of our cath lab, substantial financial loss for LRCC and, worst of all, the loss of a wonderful point of access to cardiovascular care for Medicare beneficiaries in this State.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact of the proposed methodology on procedures with significant TC costs because they share the same problems that we will outline below. We also believe that the same solution should be applied to all of the procedures listed below.

With regard to catheterizations, the proposed change in PE RVUs would result in a 53.1 percent reduction of payments for CPT 93510 TC. Similarly, payment for two related codes—93555 TC and 93556 TC would be reduced substantially. In fact, under the Medicare Physician Fee Schedule ("PFS"), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate for these three codes to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	**Description**
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom up micro-costing approach is laudable and consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comport with the statutory requirement that would match resources to payments. After reviewing the proposed methodology, including the 19 step calculation, we have identified several flaws that result in the PE RVU underestimating the resources needed to provide the technical component of cardiac catheterizations. We will address our concerns with the calculation of direct costs and indirect costs separately, as set forth below.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC–Determined Estimates

Direct Cost Category	***Included In RUC–Determined Estimate***	***Excluded From RUC–Determined Estimate***
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
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Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are not included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. There are additional improvements that can be made in the manner by which the indirect costs are estimated that are outlined below.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties – Independent Diagnostic Treatment Facilities ("IDTFs"), which account for about two-thirds of the utilization estimate for 93510 TC, and cardiology. The IDTF survey includes a wide range of facilities, but do not reflect the cost profile of cardiac catheterization facilities--that may have a cost profile similar to cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both (1) the direct costs at the procedure level, and (2) the indirect costs at the practice level.

Solutions

We believe that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization procedures and CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool ("NPWP") has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterization performed in practice or IDTF locations. The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. As a result, we request that CMS freeze payment for these cardiac catheterization-related procedure codes for one year to allow time for a complete assessment of the cost profile of the services listed in the chart provided above.

We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted to CMS to supplement these comments either separately or as part of our comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007. It is our understanding that CMS will accept additional data that helps CMS in evaluating the impact of the PE RVU methodology on our practices.

Sincerely,

Bruce E. Murphy, M.D., Ph.D.

President

Submitter : Dr. David Gagnon **Date:** 08/18/2006

Organization : dba The Red River Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a private parctice Family Practitioner in rural Kentucky. I have been in private practice for twenty-three years. The reimbursement cuts not only in Medicare, but Managed Care programs have put a tremendous burden on my small business. I have become as lean as I can in my practice, including decreasing my personal draw by 15%. My employees have not had a raise, even a cost of living raise, in over two years.
A further 5.1% decrease will make it impossible to see new Medicare patients and I may have to stop seeing my existing patient. This will put a tremendous burden on my patients as they already are located in a federally designated Health Manpower Shortage Area.
I ask you to reverse the proposed 5.1% accross the board reimbursement reduction for 2007.

Respectfully,

David Gagnon MD

Submitter : Ms. Gail katz **Date:** 08/18/2006

Organization : Gail Katz LICSW

Category : Social Worker

Issue Areas/Comments

Background

Background

Further lowering the reimbursement rate will create a situation in which social workers will be unable to cover their costs . The current payment is already lower then standard rates for the profession.

Clinicians will cease taking on these patients. This wil be particulary true of the seasoned and more experienced clinicians. It is common knowledge that there is a strong connnection between physical and mental health. Ultimately it is short sighted and will not be a fiscally sound policy.

Impact

Impact

Reduce the reimbursement for master level providers.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am a clinical social worker. I have worked with aging populations in a commuity based situation and with individuals. There is no doubt that mental health issues impact physical health.

Submitter : Dr. Danny Woo **Date:** 08/18/2006

Organization : Dr. Danny Woo

Category : Physician

Issue Areas/Comments

Background

Background

A five percent cut would already aggravate the problem associated with flat reimbursements and rising overhead. Our malpractice insurance has more than tripled. We provide increasing expensive benefits and salaries for our employees. We work greater than 80 hours per week. Much of that time being available for emergencies and not being reimbursed for being available. We may to reduce our medicare exposure, but I don't like that consideration since all people need good care. However, this cut will represent a large cut in my salary after expenses. This makes a bad situation almost intolerable. I think there will be greater ramifications in the future as fewer people will care for the Medicare patient. We make personal sacrifices with the time away from our families in order to provide around the clock care.

Impact

Impact

It is bad enough to freeze reimbursements. But it is better than the cut. Thank you for the privilege of stating my opinion.

Submitter : Mr. James Schnarre **Date:** 08/18/2006

Organization : Hillsboro Area Hospiatl

Category : Hospital

Issue Areas/Comments

Background

Background

We recommend that CMS withdraw its reduction for 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 phase "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 as required by statute." There have been no changes to subtantiate this proposed rule for the use od CAD with ANALOG MAMMOGRAPHY.

James Schnarre
Hillsboro Area Hospital
1200 E. Tremont
Hillsboro, IL 62049
8/18/06

RE: CMS-1512-PN

CPT Codes 76082 and 76083

Provisions of the Proposed Rule

Provisions of the Proposed Rule

We recommend that CMS withdraw its reduction for 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 phase "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 as required by statute." There have been no changes to subtantiate this proposed rule for the use od CAD with ANALOG MAMMOGRAPHY.

James Schnarre
Hillsboro Area Hospital
1200 E. Tremont
Hillsboro, IL 62049
8/18/06

RE: CMS-1512-PN

CPT Codes 76082 and 76083

Submitter : **Judy Martin** **Date: 08/18/2006**

Organization : **Judy Martin**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

Re: CMS-1512-PN.
A 14 percent reimbursement cut will affect my practice and me as a Medicare provider making it even more difficult to continue to serve a senior population in need of mental health services and earn a living wage.
I request 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; and
I request that CMS not approve the proposed Top down formula to calculate practice expense, and instead select a formula that does not create a negative impact for mental health providers.

GENERAL

GENERAL

Re: CMS-1512-PN
A 14 percent reimbursement cut will affect my practice and me as a Medicare provider making it even more difficult to continue to serve a senior population in need of mental health services and earn a living wage.
I request 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; and
I request that CMS not approve the proposed Top down formula to calculate practice expense, and instead select a formula that does not create a negative impact for mental health providers.

Submitter : Dr. Marilyn Esobedo **Date:** 08/19/2006

Organization : Dr. Marilyn Esobedo

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The across the board reduction in reimbursement will negatively impact the access to health care of many, particularly children on Medicaid.

Submitter : Dr. Beth Wheeling **Date:** 08/19/2006

Organization : BethWheeling, Psy.D.

Category : Social Worker

Issue Areas/Comments

Background

Background

You will force more providers of psychotherapy to go to fee for service, rather than insurance or medicare reimbursement if you lower fees to psychologists.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am a clinical psychologist

Submitter : Dr. Eugene Sinclair **Date:** 08/19/2006

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 : Dr. Linda Love **Date:** 08/20/2006

Organization : Dr. Linda Love

Category : Social Worker

Issue Areas/Comments

Background

Background

The impact of this reduction would prevent the profession from taking on more Medicare clients as the income does not pay for the expenses that it takes to run a practice. I would have to seriously consider dropping my contract as it is no cost effective and many clients would be restricted from care. More and more physicians are not taking medicare clients b/c of the low pay scale and patients are not receiving quality care. Please reconsider this as the cost of being a practioner would outweigh the income proposed.

Submitter : Dr. Carol Beals

Date: 08/20/2006

Organization : Beals Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1321-P-71-Attach-1.DOC

Attach #
71

The Honorable William H. Frist, M.D.
Senate Majority Leader
United States Senate
Washington, DC 20510

The Honorable Harry Reid
Senate Minority Leader
United States Senate
Washington DC 20510

Dear Majority Leader Frist and Minority Leader Reid:

This request pertains to the payment cuts for physicians and health care professionals to be effective January, 2007. As a private solo practioner in the field of rheumatology, I respectfully urge you to ask congress not to cut payments. To further cut reimbursements for the medicare population will markedly limit access of care for the people who need it the most. The projected cuts will endanger the access and the health to a large number of Americans.

In my field of rheumatology the number of providers are shrinking at an alarming rate. The need for care of arthritis and autoimmune diseases is increasing as the population ages. It is becoming increasingly difficult to keep medical offices open and accessible to the medicare and Tricare patients. Careful consideration of reimbursement and access to this care becomes more of an issue as each month passes. The proposed cuts if imposed will decrease payment rates by 20% below inflation costs for the past six years. The economics of running a practice is, even now, limiting any new technology to be purchased for the office. The stark reality that longer hours mean less income or barely breaking even is disheartening. I practice in a small city and the number of physicians leaving medicine is alarming.

As you well may be aware by a recent survey of the AMA 45% of physicians plan to decrease the number of medicare patients and 43% said they will decrease the number of Tricare patients.

As a solo practioner and a member of the AMA,ARA,MSMS,and ISCD,I respectfully request that the congressman reject this proposed cut inreimbursement.

Respectfully,

Carol A. Beals,M.D.
4333 W.St. Joseph Hwy.
Lansing, Mi. 49017

Submitter : Dr. Jennifer Root **Date:** 08/21/2006

Organization : Dr. Jennifer Root

Category : Physician

Issue Areas/Comments

Background

Background

As usual, the government needs to cut costs. And as usual, they do it on the backs of physicians. Most of us are convinced that CMS WANTS us to stop accepting medicare because it would save them alot of money NOT paying for services. As it is, current payment methodology has penalized anesthesia unfairly when compared to the rest of medicine, and failing to address this inequity yet continuing to cut fees for our services has placed us in the bottom percentile of all physicians in reimbursal rates compared with commercial. I don't have to accept medicare! But my collegues who are involved in teaching the next generation of anesthesiologists are currently so heavily impacted by these payment cuts that they are on the brink of being unable to have the manpower to run academic departments. Combined with the unfair CMS rule restricting anesthesia compared to other specialtys with more restrictive supervision ratios and you are going to kill our specialty. Nice to see all our work over the past 40 years making surgery and anesthesia safer than ever is going to get tossed out with the bathwater by the beaurocrats.

Submitter : Dr. Lincoln Godfrey **Date:** 08/21/2006

Organization : SHM

Category : Physician

Issue Areas/Comments

Background

Background

As the fastest growing specialty in medicine, Hospitalists now have both the most demand and an ever-increasing role in management. A decision made today will affect twice as many physicians in 5 years as it does now.

GENERAL

GENERAL

I founded a hospitalist program in Mountain Home, AR at Baxter Regional Medical Center nearly 5 years ago. At that time it was a independent corp with a single employee. We now have hospitalists in place to manage 3/4 of all medical admissions and work daily to improve quality while optimizing patient satisfactions and short length of stays. We remain independent.
The work load has become much larger as we've implemented several strategies to improve throughput, improve outcomes, and meet quality indicators as set forth by CMS and AFMC.
I urge you to finalize the recommended work RVU increases for E & M services as recognition for this increasing complex service. This will make it possible for me to recruit the very competitive qualified help I need, and implement continuing quality improvement.
Please reject any efforts to lower the proposed improvements in work RVUs for E&M services. Thank you for your kind consideration of this very important matter.

Impact

Impact

Improved reimbursement for E&M codes.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See below...

Submitter : Ms. Stefani Sheppa **Date:** 08/21/2006

Organization : LCSW- Private Geriatric Practice

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Dear HHS Staff, I am writing about CMS-1512-PN, which is proposing a substantial fee reduction for clinical social workers as of 1/1/07 and beyond. As a Licensed Clinical Social Worker in New Jersey, i provide services to older adults in the community and to those in Assisted Living facilities. These proposed cuts to reimbursement will have a significant negative impact on the services that i provide, and will cause me to reevaluate as to whether my practice can survive. Given that the numbers of older adults are increasing, and the need for mental health services is increasing also, as people are living longer, and dealing with many more chronic medical issues than ever before, along with issues such as the death of a spouse, the need to move out of one's home and to a supportive residence, and the concurrent anxiety, depression, substance abuse issues that occur, along with the caregiving needs of families, these proposed cuts will undercut the sevices that older adults need to live and function in the community adaptively. Fewer clinical social workers will be able to provide the kinds of individual, group and family therapy that will help these older adults. This could result in increased inpatient or medical costs, as older adults lapse into 'crisis' without the needed clinical interventions to avert mental health issues as they arise. Also, the need for family or individual support and mental health intervention is needed for many families dealing with dementia and Alzheimer's disease. These illneses , along with chronic diabetis, heart disease, and others, are increasing, and often have a concurrent mental health need. Decreasing the reimbursement rate,will diminsh the availability and access to services, and have a detrimental impact. In fact, the reimbursement rates should be increasing, instead , to follow the demographics for increasing numbers of aging baby boomers and older adults! Please do not reduce work values for clinical social workers as proposed for 1/1/07. Also, Please select a formula for reimbursement that does not create a negative impact for social workers who are providing these essential mental health services. Thank you for your thoughtful consideration of these issues, and i respectfully request that this proposal be revised . Sincerely, Stefani Sheppa, LCSW

Submitter : Ms. Amy Strom **Date:** 08/21/2006

Organization : Achievement Centers for Children

Category : Social Worker

Issue Areas/Comments

Background

Background

I feel the number of families that would no longer be able to recieve counseling if fees were raised. Likewise, if fees were decreased for social workers, non-profit and/or United Way Agencies would have a difficult time paying licensed profressionals to continue services. As it is, many of the social workers at my agency are underpaid and receive less than the cost of living expenses in raises on a yearly basis. Due to the complexity of many of these families issues, providing services by licensed professionals is a must and by reducing payment fees this may no longer be possible!

Submitter : **Debra Ness** **Date: 08/21/2006**

Organization : **National Partnership for Women and Families**

Category : **Consumer Group**

Issue Areas/Comments

Background

Background

Impact

Impact

August 17, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 314-G
Washington, D.C.

Re: CMS-1321-P- Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007

Dear Dr. McClellan:

The National Partnership for Women & Families is a nonprofit, nonpartisan organization that uses public education and advocacy to promote quality health care for women and their families. It has come to our attention that CMS proposed physician fee schedule rule (referenced above) would make significant cuts in Medicare reimbursements for technologies used in screening for osteoporosis and breast cancer. We understand that CMS is proposing to decrease reimbursement:

-for dual-energy x-ray absorptiometry (DXA), the most accurate method for measuring bone density, by 75%;
-for computer aided detection (CAD) as an adjunct to mammography, by 52%; and
-for stereotactic guided breast biopsy, a less invasive alternative to surgical biopsy for some women, by 80%.

We share CMS s concern that federal spending on imaging services under the Medicare physician fee schedule has increased by an alarming $7 billion annually since 2000. But given the size of these reimbursement cuts and the importance of these particular technologies to women s health we ask CMS to carefully examine the potential impact of these reductions on women s access to important screening and diagnostic services before moving further.

Sincerely,

Debra L. Ness

CMS-1321-P-76-Attach-1.PDF

Attachment 76

National Partnership
for Women & Families

August 17, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 314-G
Washington, D.C.

Re: CMS-1512-PN, RIN 0938-A012, 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:

The National Partnership for Women & Families is a nonprofit, nonpartisan organization that uses public education and advocacy to promote quality health care for women and their families. It has come to our attention that CMS' proposed physician fee schedule rule (referenced above) would make significant cuts in Medicare reimbursements for technologies used in screening for osteoporosis and breast cancer. We understand that CMS is proposing to decrease reimbursement:

-for dual-energy x-ray absorptiometry (DXA), the most accurate method for measuring bone density, by **75%**;

-for computer aided detection (CAD) as an adjunct to mammography, by **52%**; and

-for stereotactic guided breast biopsy, a less invasive alternative to surgical biopsy for some women, by **80%**.

We share CMS's concern that federal spending on imaging services under the Medicare physician fee schedule has increased by an alarming $7 billion annually since 2000. But given the size of these reimbursement cuts – and the importance of these particular technologies to women's health – we ask CMS to carefully examine the potential impact of these reductions on women's access to important screening and diagnostic services before moving further.

Sincerely,

Debra L. Ness
President

1875 Connecticut Ave. NW / Suite 650 / Washington, DC 20009 / 202.986.2600 / www.nationalpartnership.org

Submitter : Dr. Stephen Greer **Date:** 08/21/2006

Organization : Arkansas Cardiology, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1321-P-77-Attach-1.DOC

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

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

Submitter : Mr. Karl Turner **Date:** 08/21/2006

Organization : Southwest Washington Medical Center

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Outpatient rehab is a very small percentage of Medicare's cost for services. This fee reduction would potentially reduce access for many Seniors, and have a negative impact on the rehab business.

Submitter : **Dr. Debra Lawrence** **Date: 08/21/2006**

Organization : **Conway Women's Health Center**

Category : **Physician**

Issue Areas/Comments

Background

Background

Dear Dr. McClellan:

I am gravely concerned about the proposed drastic cuts in payment for dual energy X-ray absorptiometry (DXA; CPT code 76075) and vertebral fracture assessment (VFA; CPT code 76077). These cuts have been proposed as part of a new five-year review of the Medicare Physician Fee Schedule.

If these cuts are not reversed, when fully realized in 2010, they would amount to a decline in payment of 71% for DXA and 37% for VFA.

It is my opinion that this action will severely reduce the availability of high quality bone mass measurement, having a profound adverse impact on patient access to appropriate skeletal healthcare.

Ironically, these proposed cuts for DXA and VFA testing for patients with suspected osteoporosis are completely contrary to recent forward-looking federal directives. Multiple initiatives at the Federal level including the Bone Mass Measurement Act, the US Preventive Services Task Force recommendations, the Surgeon General s Report on Osteoporosis, as well as your recent Welcome to Medicare letter, all highlight the importance of osteoporosis recognition using DXA, and the value of appropriate prevention and treatment to reduce the personal and societal cost of this disease. HEDIS guidelines and the recent NCQA recommendations also underscore the value of osteoporosis diagnosis and treatment in patients at high risk.

These patient-directed Federal initiatives, coupled with the introduction of new medications for the prevention and treatment of osteoporosis, have improved skeletal health and dramatically reduced osteoporotic fractures, saving Medicare dollars in the long run.

Moreover, in contrast to other imaging procedures where costs are escalating but improvements in patient outcome have not been clearly demonstrated, DXA and VFA are of relatively low cost and of proven benefit. Additionally, DXA and VFA are readily available to patients being seen by primary care physicians and specialists alike, thus assuring patient access to these essential studies.

Importantly, it appears that some of the assumptions used to recalculate the Medicare Physician Fee Schedule were inaccurate. For example, CMS calculated the equipment cost at less than half of what it should be, because they based it on older pencil beam technology that is now infrequently used. They also calculated the utilization rate for this equipment at a falsely high rate that does not reflect the average use of equipment used to evaluate single disease states. Rather than the 50% rate assigned, DXA and VFA equipment utilization rates should be estimated at 15-20%. In addition, many densitometry costs such as necessary service contracts/software upgrades and office upgrades to allow electronic image transmission were omitted. Finally, CMS concluded that the actual physician work of DXA interpretation is "less intense and more mechanical" than was accepted previously. This conclusion fails to recognize that high quality DXA reporting requires skilled interpretation of the multiple results generated by the instrument.

I urge you to withdraw these substantial cuts in the proposed rule that reduces Medicare reimbursement for these important technologies used to screen people at risk for osteoporotic fracture. The aging of the US population provides a clear demographic imperative that this preventable disease be detected and treated, thereby preventing unnecessary pain and disability, preserving quality of life and minimizing the significant societal costs associated with bone fractures. Please do all you can to support bone health and quality patient care by requesting that these proposed cuts be reversed.

Thank you,

Debra Lawrence, M.D.
2200 Ada Ste 301
Conway, AR 72034
501-450-3920

Submitter : Dr. Roy Thompson **Date:** 08/21/2006

Organization : Rocky Moutain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

Submitter : Dr. Nelson Trujillo **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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CENTERS FOR MEDICARE AND MEDICAID SERIVICES
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Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Chuck Rogers **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
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Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Bryan Reynolds **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

Submitter : Dr. Daniel White **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

Submitter : Dr. John Schutz **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

Submitter : Dr. Jim Chapman **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

Submitter : Dr. Sameer Oza **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

Submitter : Dr. John McNeil **Date:** 08/21/2006

Organization : Rocky Mountain Cardiology, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

Submitter : Dr. Russel Glaun **Date:** 08/22/2006

Organization : Russel S Glaun MD PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a dermatologist and dermatopathologist and have been practicing in Florida since 1996. Based on my personal experience, the past three or four years have seen two changes which have had a significant impact on the performance of the professional component by the physician pathologist.

Firstly my malpractice insurance cost has tripled compared to four years ago because pathology has been reclassified as Class 2 risk. I have not had any claims which would adversely affect the rate. My other field of dermatology, while also experiencing an increase in rate, has not however been changed to a different risk category. I currently pay approximately $39,000 per year for $500,000 each claim/$1,500,000 aggregate coverage through my carrier First Professionals Insurance Company of Jacksonville, Florida. The rate for a dermatologist with the same coverage limits is approximately $13,000 per year which is what a pathologist would have paid had there been no risk category change. This change in practice expense is borne solely by the pathologist physician who is compensated at the professional component rate. To the best of my knowledge the laboratory performing the technical component does not share this insurance expense. This distinction is important for pathologists whether they are part of a laboratory that bills globally or, as in my case, an office based pathologist who utilizes an outside laboratory to perform the technical component and therefore bills Medicare for the professional component only.

Secondly, due to the more common use of electronic medical records in medical practice in general and by extension pathology software programs that enable pathologists to type in the pathology microscopic diagnosis, pathologists are spending more time generating the final pathology report compared to a few years ago. This extra time is essentially time that laboratories previously would have paid a transciptionist for. This extra work involves getting on line to access the software program, entering the pathology diagnosis and microscopic description, reviewing and making any corrections to the final report and electronically signing the report. Although it is difficult to quantify this extra work precisely, my best estimate, based on my experience with two different pathology software programs, is that it adds approximately two minutes to each specimen reported. This is over and above the time needed to simply dictate and sign a printed report.

I do not know if these comments are more germane to this notice (CMS-1321-P), the five-year review of work RVUs under the Physician Fee Schedule (CMS-1512-PN) or indeed both. I respectfully submit these comments for consideration.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The CPT codes most commonly used by a histopathologist when rendering a microscopic diagnosis are 88304, 88305, 88307, 88312, 88313 and 88342, all of which are global codes composed of a technical component (TC modifier) and a professional component (26 modifier). The technical component is performed by a histotechnologist while the professional component is performed by a physician (pathologist).

Submitter : Dr. William Taylor **Date:** 08/22/2006

Organization : St. John's Health System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would urge as a practicing internist that the proposed changes in the work RVU be implemented. As patients have aged and medicine has advanced we are taking care of older, sicker, and more complex patients all the time. Our costs have continued to go up and Medicare payments have not kept pace. It is more difficult to attract new doctors into general internal medicine. My practice has not been able to attract a new partner for the last year. Fewer medical school graduates are going into general internal medicine, instead opting for subspecialties.

Our payments in the hospital have not kept up with inflation such that it is not cost effective to see hospitalized patients. The proposed changes in hospital payments will help to keep doctors treating patients in the hospital.

The paperwork burden we now endure is tremendous. The cost of electronic charting is born by the doctors with little in return. The work RVU's need to be looked at regularly.

I would also argue against any cut in the medicare conversion factor. Any cut next year would wipe out other gains and negate progress. Already doctors are refusing new Medicare patients in my community and this can get worse. Medicare patients are thankful when I agree to see them as patients. They are finding it harder and harder to find a doctor who will see them. I take a 30 percent cut in pay when I see a Medicare patient compared to a non-Medicare patient.

Please keep these needed increases in place so that when I am Medicare age I will be able to find a doctor to see me!

William K. Taylor, MD, FACP

Submitter : **Ms. anne Stephansky** **Date: 08/22/2006**

Organization : **Anne Stephansky**

Category : **Social Worker**

Issue Areas/Comments

Background

Background

CMS 1512 -PN I take Medicare patients, and basically, my insured patients subsidize them. I could not stay in practice if I just got the 40$ Medicare pays. My patients report its hard for them to find therapists who accept Medicare.

Submitter : Dr. Jonathan Weiss **Date:** 08/22/2006

Organization : Sullivan Internal Medicine Group

Category : Physician

Issue Areas/Comments

Background

Background

The proposed 5.1% Medicare cut for 2007 is untenable for practicing physicians. Costs inevitably go up and unlike virtually any other business, physicians are restricted by external forces in adjusting fees accordingly. If cost containment is the goal, rather than target the physicians who provide care for our increasingly aged and ill population under ever more difficult circumstances, try addressing issues like reducing outrageous malpractice settlements. Such interventions will have ripple effects such as a decrease in excess testing and office visits that have become an issue according to the latest Part B News.

Submitter : Terry O'Neill **Date:** 08/23/2006

Organization : National Council of Women's Organizations

Category : Consumer Group

Issue Areas/Comments

Impact

Impact

The National Council of Women s Organizations (NCWO) is a nonpartisan, nonprofit umbrella organization of groups that collectively represent over ten million women across the United States. Our over 200 member organizations collaborate through substantive policy work and grass roots activism to address issues of concern to women, including access to affordable and comprehensive health care throughout one's life.

We are pleased that the Administration has taken steps to move toward a preventive model of health care, but were concerned to recently learn of drastic reimbursement cuts in women s health services outlined in the proposed rules referenced above. If implemented, these cuts could endanger the health of American women and undermine, if not reverse, recent advances in screening rates and early detection of osteoporosis and breast cancer.

As you are aware, osteoporosis and breast cancer, which overwhelmingly affect women, are two of the nation s most prevalent diseases with risk factors associated with increasing age. The effects of both can be minimized through early detection and treatment. Yet, in spite of recent public efforts to raise awareness of the availability of effective screening tools, utilization, particularly for osteoporosis, remains substandard. The public policy response should be to increase, not decrease, the use of these tools.

We understand that the proposed rules suggest cutting reimbursement for central DXA, the gold standard of osteoporosis screening, by 75% and Vertebral Fracture Assessment, an early detection of spinal fractures, by 50%. Cuts of this magnitude will have the effect of limiting access to high-quality preventive and diagnostic procedures. With screening utilization already at the unacceptably low level of under 25%, we are concerned that the proposed rules will surely push utilization rates in the wrong direction.

Similar access issues exist for mammography, the best tool we have to detect breast cancer. A recent GAO report highlights how a decrease in the number of mammography machines affects women (GAO, "Mammography: Current Nationwide Capacity Is Adequate, but Access Problems May Exist in Certain Locations," 7/25). Mammography itself is not negatively impacted by the proposed rules, but one of the newest and most significant technologies to enable earlier detection of breast cancer, Computer Aided Detection (CAD), is. Reimbursement for CAD as an adjunct to mammography would be decreased by over 50%, making its use economically infeasible in many places, particularly in small to medium sized practices, and rural areas where it is needed the most. CAD has been shown to increase the detection rate of breast cancers by 20% or more, and has become standard of care in most practices.

Breast cancer diagnosis will also be negatively impacted under the proposed rules. In recent years technical advances have made it possible to perform breast biopsies on patients using minimally invasive techniques, such as stereotactically guided imaging. This alternative to surgical biopsy would be cut by 80%, having the inevitable effect of forcing women to undergo open surgical procedures.

We believe it is in the public s best interest to ensure that access to screening services for osteoporosis, high quality mammography, and minimally invasive breast biopsy technologies remain available and affordable. We urge you to review and revise these proposed cuts to ensure that these technologies remain available to all Medicare beneficiaries.

Sincerely,

Terry O Neill
Executive Director
National Council of Women s Organizations

CMS-1321-P-93-Attach-1.DOC

Attachment 93

August 23, 2006

The Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1512-PN
CMS-1312-P

Dear Dr. McClellan:

The National Council of Women's Organizations (NCWO) is a nonpartisan, nonprofit umbrella organization of groups that collectively represent over ten million women across the United States. Our over 200 member organizations collaborate through substantive policy work and grass roots activism to address issues of concern to women, including access to affordable and comprehensive health care throughout one's life.

We are pleased that the Administration has taken steps to move toward a preventive model of health care, but were concerned to recently learn of drastic reimbursement cuts in women's health services outlined in the proposed rules referenced above. If implemented, these cuts could endanger the health of American women and undermine, if not reverse, recent advances in screening rates and early detection of osteoporosis and breast cancer.

As you are aware, osteoporosis and breast cancer, which overwhelmingly affect women, are two of the nation's most prevalent diseases with risk factors associated with increasing age. The effects of both can be minimized through early detection and treatment. Yet, in spite of recent public efforts to raise awareness of the availability of effective screening tools, utilization, particularly for osteoporosis, remains substandard. The public policy response should be to increase, not decrease, the use of these tools.

We understand that the proposed rules suggest cutting reimbursement for central DXA, the gold standard of osteoporosis screening, by 75% and Vertebral Fracture Assessment, an early detection of spinal fractures, by 50%. Cuts of this magnitude will have the effect of limiting access to high-quality preventive and diagnostic procedures. With screening utilization already at the unacceptably low level of under 25%, we are concerned that the proposed rules will surely push utilization rates in the wrong direction.

Similar access issues exist for mammography, the best tool we have to detect breast cancer. A recent GAO report highlights how a decrease in the number of mammography machines affects women (GAO, "Mammography: Current Nationwide Capacity Is Adequate, but Access Problems May Exist in Certain Locations," 7/25). Mammography itself is not negatively impacted by the proposed rules, but one of the newest and most significant technologies to enable earlier detection of breast cancer, Computer Aided

Detection (CAD), is. Reimbursement for CAD as an adjunct to mammography would be decreased by over 50%, making its use economically infeasible in many places, particularly in small to medium sized practices, and rural areas where it is needed the most. CAD has been shown to increase the detection rate of breast cancers by 20% or more, and has become standard of care in most practices.

Breast cancer diagnosis will also be negatively impacted under the proposed rules. In recent years technical advances have made it possible to perform breast biopsies on patients using minimally invasive techniques, such as stereotactically guided imaging. This alternative to surgical biopsy would be cut by 80%, having the inevitable effect of forcing women to undergo open surgical procedures.

We believe it is in the public's best interest to ensure that access to screening services for osteoporosis, high quality mammography, and minimally invasive breast biopsy technologies remain available and affordable. We urge you to review and revise these proposed cuts to ensure that these technologies remain available to all Medicare beneficiaries.

Sincerely,

Terry O'Neill
Executive Director
National Council of Women's Organizations

Submitter : Mrs. Cynthia Simons **Date:** 08/23/2006

Organization : Mrs. Cynthia Simons

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Criteria for National Certifying Bodies-Advanced Practice Nurses
As a Clinical Nurse Specialist certified in Palliative Care I strongly support the proposed rule of allowing The National Board on Certification of Hospice and Palliative Care Nurses (NBCHPN) to be added to the list of recognized certifying bodies. It is my most important concern to keep patients comfortable physically, emotionally, and spiritually while they are dealing with a life-limiting illness. With my training in hospice and palliative care and the support of the NBCHPN and CMS it will be possible to make patients comfortable and help their families deal with the distresses and burdens of life-limiting illnesses.
Thank you so much,

Cindy Simons, APRN, BC-PCM
Palliative Care Clinical Nurse Specialist
Hospice of Central Ohio
2269 Cherry Valley Rd
Newark, Ohio 43055
740-344-0311

Submitter : Dr. Nga Collard **Date:** 08/23/2006

Organization : Nga Collard, M.D., PSC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would like to say that we are doing the job of the internist, we refer to specialists. I feel that this decrease is unfair.
Thank you,
Dr. Nga Collard

Submitter : Dr. Patricia Stafford **Date:** 08/23/2006

Organization : Women's Imaging & Wellness, Inc.

Category : Radiologist

Issue Areas/Comments

Background

Background

Significant reductions in reimbursement for technologies used to screen for osteoporosis and breast cancer will have a severe negative impact on services offered to patients.

GENERAL

GENERAL

I am writing to call attention to the proposed rule which would make substantial reductions in reimbursement for technologies used to screen for osteoporosis and breast cancer. These cuts to basic preventative services, described more fully below, seem at odds with your commitment to disease prevention, and the "Welcome to Medicare" physical exam which you instituted. In fact the physical is described in part as "a great way to get up to date on important screenings". I hope that you will review these proposed cuts in light of the public-health mission of your agency, and withdraw them.

The goal standard for bone mineral density testing is a central DXA (axial dual-energy x-ray absorptiometry), the only method recognized by the International Society for Clinical Densitometry and the International Osteoporosis Foundation for the diagnosis of osteoporosis. At least 75% of all bone densitometry screening exams are performed using central DXA. Despite the fact that screening rates for the Medicare population remains below 25%, CMS proposes to cut reimbursement for central DXA by 75%.

To address the problem of missed breast cancers, academic and industry research groups worked to develop sophisticated computer algorithms to identify features on mammograms that are suspicious for breast cancer. The result was CAD (Computer Aided Detection), which has led to dramatic increases in the number of cancers detected and detected at an earlier stage of the disease. Women enjoy improved likelihood of survival and less aggressive treatment options. Despite the benefits CAD offers women in screening and diagnosis, the proposed role would cut Medicare reimbursement for CAD by 54%.

Finally, the proposed rule cuts reimbursement for stereotactic guided breast biopsy, a minimally invasive alternative to open surgical biopsies.

Minimally invasive biopsies generally require some form of image guidance, either ultrasound or stereotactic (x-ray based). Stereotactic is the predominant guidance technology used with vacuum assisted breast biopsy devices, due to device maneuverability and patient positioning requirements. In addition, stereotactic imaging, unlike ultrasound, makes it possible to see microcalcifications -- sub-centimeter tissue abnormalities -- critical in determining the presence of early breast cancer. The proposed rule would cut stereotactic guided biopsy by 80%.

I think you will agree that cuts of this magnitude to basic preventative services, as well as a minimally invasive form of breast biopsy, would have the effect of limiting access to critical, life-saving technologies to the women most at risk for osteoporosis and breast cancer. Thank you for your attention to this matter. I look forward to hearing from you.

Sincerely,
Patricia A. Stafford, M.D.

Impact

Impact

CMS proposes to cut reimbursement for central DXA by 75%, CAD (computer-aided detection) in combination with mammography by 54% and stereotactic guided biopsy by 80%.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am a diagnostic radiologist specializing in women's imaging including mammography, breast biopsy and DXA. As a solo private practitioner, I have made significant investments in new technologies (including education for my staff) as they have become available because I believe patients have the right to the elevated "standard of care" that is provided by these important technologies. With cuts in reimbursement, it will become virtually impossible to continue to meet the standards that I have sent for my practice and that my patients deserve.

Submitter : Dr. Clara Ann Pallares **Date:** 08/23/2006

Organization : Louisville Internal Medicine & Pediatrics,LLC

Category : Physician

Issue Areas/Comments

Background

Background

I am extremely disappointed with the proposed decrease in reimbursement. As and Internist, my reimbursement is already disgraceful. As physicians' cost of running an office continues to increase (as does the cost of living), the proposed continued decreases in reimbursement make it more and more difficult to stay in practice and to continue to see Medicare patients. These patients are the most complicated and require the most time and effort; yet we do not even get reimbursed enough to cover our time and supplies. This is also causing many Primary Care Physicians to either retire or to re-train in other fields, and people coming out of medical school are not choosing Primary Care fields to go into. It does not even make sense to me that there are proposed cuts to our reimbursement when there are cost of living increases and proposed minimum wage increases; and we should give our employees cost-of-living raises. But this proposed continued decrease in our reimbursement is putting us all out of business and jeopardizing the care of our elderly population, who need physicians the most. Please consider an increase, rather than a decrease, in our reimbursement. Keep in mind that other insurance companies usually follow suit with Medicare reimbursement, and we simply cannot afford continued cuts. As it stands, if the proposed cuts go through, I will discontinue to see Medicare patients, as will many other Primary Care Physicians in this area. This is a very important topic and articles are in newspapers (making the public aware of the problem)and in our medical literature. I also make my patients aware of the problem so they will understand why they cannot find doctors to see them.

Submitter : Ms. francine summers **Date:** 08/23/2006

Organization : action rehab

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

What are you think?? the Demise of the Private Practice
My name is Francine I am an owner of a private practice for 16 years and in that 16 years I have seen our industry of physical therapist beat up and spit out by insurance companies. The proposed five year review will not only hurt the therapist but more the patient care. unfortunately cash is critical to a private business because the business has bills to pay. Why is the cost of living going up but our pay going down. The rent for the health care facility and the cost of QUALITY up to date equipment to treat patients cost more but we are paid less. How can I afford to keep treating Medicare patients when that hour will cost me more in paying staff,rent and supplies along with all the other things that go in to treating a patients ,the hours spent after seeing the patient making
sure the documentation is clear and complete which is time we do not get reimbursed for .We also have the on going expense of electric ,phone, water ,insurances and supplies like sheets and towels that have to be washed and clean every time we see a patient. How can I keep QUALITY therapist working who have doctorates in physical therapy when you have to pay for thier salary, health insurance, malpractice insurance oh and do you want them to keep up to date on therapy techniques well that requires paying for continuing education and that requires cash..
So the bottom line is we have already dealt with a therapy cap patients have to suffer because regardless of weather they could of used more therapy or not they will have to pay out of pocket and most patients can not afford that on a set income . If this 5 year review goes in to effect then as a practice I do not see any way we will be able to continue to see patients that are Medicare because I will not compromise quality of care at this facility.

Submitter : **Ms. Deanna Brame** **Date: 08/23/2006**

Organization : **Bozeman Deaconess Palliative Care**

Category : **Nurse**

Issue Areas/Comments

Background

Background

The acceptance of the CMS-1321-P including recognition of NBCHPN as the certifying body for APN in Hospice and Palliative care is essential to patient care.

GENERAL

GENERAL

I completely support the NBCHPN as the cerfifying body for APNs in Hospice and Palliative Care. Recognition and the ability to bill for these valuable services and specialty is a necessary to quality care for patients.

Submitter : Mr. Noel Rhodes **Date:** 08/24/2006

Organization : Spartanburg Regional Health Service District, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

Computer-aided detection provides improved physician detection capability in a highly litigious medical arena. Small facilities and facilities which are limited on Radiologist availability and cannot provide consistent double-reads are provided opportunity to increase detection of lesions with use of CAD. Decreasing reimbursement will increase the ROI (return on investment) time frame making this purchase non-feasable for small facilities. The patient care impact can be significant. A major portion of mammography patients have Medicare or Medicaid and may or may not have supplemental coverage. The impact on increased cancers missed due to non-availability of this enhancement tool will subsequently increase costs for treatment to Medicare/Medicaid and their covered participants. Reduction of payment should be weighed very carefully against the current percentage of missed breast cancers without the use of CAD and the percent of missed with use of CAD.

Noel R. Rhodes
Director, Imaging and Neurophysiology
Spartanburg Regional Health Services District, Inc.

Submitter : Mrs. Amy Guthrie **Date:** 08/24/2006

Organization : Hospice of the Western Reserve, Cleveland OH

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I support and approve the proposal to officially recognize NBCHPN as an approved national certification organization for advanced practice nurses.

Submitter : Dr. Josef Grabmayer **Date:** 08/24/2006

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As an anesthesiologist and a member of the American Society of Anesthesiologists (ASA), I am writing today to ask that you take every possible action to prevent cuts in Medicare payments to physicians for 2007 by repealing and replacing the unfair SGR formula.

Averting this crisis is more important now than ever because of new proposals released by CMS that would amount to a 10% cut in Medicare payment to anesthesiologists over the next four years. This proposed cut, on top of potential SGR-related reductions, could irreparably damage my specialty.

The current SGR formula, based as it is on changes in the gross domestic product, has proven unworkable essentially because changes in economic growth have little to do with the demand for medical services or the increasing cost of delivering them. If payments are cut in 2007, then Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years.

ASA favors the update mechanism previously recommended by MedPAC, in which the SGR would be replaced by a system that reflects increases in practice costs and other medical inflation variables. For 2007, MedPAC has recommended a Medicare physician payment update of 2.8%.

Evidence is growing that anesthesiologists and other physicians are seeking practice settings where the need to provide care to Medicare beneficiaries is at a minimum. With a nationwide shortage of anesthesia providers, this trend suggests a looming access crisis for many Medicare beneficiaries to surgical, pain medicine and critical care services.

Please work to fix the flawed SGR formula to avert further devastating cuts to the medical specialty of anesthesiology.

Submitter : Denice Sheehan **Date:** 08/25/2006

Organization : Denice Sheehan

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I support adding the National Board of Certification of Hospice and Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies.

Submitter : Ms. tj moore **Date:** 08/25/2006

Organization : st Anthony's hospitatl

Category : Hospital

Issue Areas/Comments

Background

Background

I would like to respond to the proposed rule regarding Critical Care. I think it would be fair to say that coding/billing on the facility side based on time is really not a 'clear' picture of the labor intensive activities involving a critical ill patient. What we are seeing here at our facility is inconsistent documentation by the staff who are marking levels of care versus what the Physician is documented. One of the concerns I have is proposing that the nursing staff decide whether the patient should be billed as critical care and then find that the Physician has not documented critical care time in his notes. I am sure that clinical staff are aware of the patient being critically ill; however, that criteria should based on the resources that are being utilized to take care of these patients. The Critical Care time guideline is for the work of the physician and is totally separate from the work of the facility. What we are finding here in our facility is that critical care is being missed or not documentedf appropriately only to find that the Physician has documented something totally different. It is most useful to indicate the resources that are being utilized by the nurses to take care of a crtically ill patient. The time element you are proposing does not indicate the resources used by the facility to handle these patients. The time indicated in the CPT is a great guideline for the physician but does not indicate the 'resources' utilized by the nursing staff to take care of these patients.

Submitter : **Roger Moore** **Date: 08/25/2006**

Organization : **Roger Moore**

Category : **Physician**

Issue Areas/Comments

Background

Background

The proposed rule included a 6% cut in total payments to anesthesiologists due to the Five Year Review, and an additional 1% cut every year through 2010 due to a new practice expense methodology. This would amount to a devastating 10% cut in Medicare payments to anesthesiologists over the next four years the largest cut to any medical specialty. Medicare has grossly undervalued anesthesia work within CMS.

GENERAL

GENERAL

A positive 2.8% payment update in 2007, as recommended by MedPAC is what should occur. Congress should repeal the unworkable SGR formula and replace it with a system of positive updates based on the MEI.

Impact

Impact

The two proposed cuts in the June 29 rule, along with the anticipated Sustainable Growth Rate (SGR) rollback, form a Medicare payment triple threat for anesthesiologists. In the August 22 Federal Register, CMS issued its proposed rule for the 2007 Medicare Physician Fee Schedule, which projects a negative 5.1% SGR update to payment rates for all physicians in 2007 more than the 4.6% cut originally projected.

Also, CMS continues to impose a 50% payment penalty for teaching anesthesiologists who oversee residents on overlapping cases. This policy costs anesthesiology teaching programs an average of $30 million to $40 million each year.

Submitter : Dr. Karen Erbeck **Date:** 08/25/2006

Organization : Dr. Karen Erbeck

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly oppose the plan for reduction of 2007 Medicare Payments. Medicine is becoming more complex,requiring the physician to spend more time on each patient. Reducing fees sends the message that our time and our expertise are not valued. If this passes, it will definitely impact my vote in the next election, and those of my colleagues. Please support physicians in their efforts to provide excellent, comprehensive care. Thank you.

Submitter : Dr. Zaneta Strouch **Date:** 08/26/2006

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

Background

Background

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. Anesthesiologists face a 10% cut in Medicare payment over the next four years due to changes in practice expense and work values. Potential SGR-related reductions, on top of further proposed cuts, could irreparably damage the medical specialty of anesthesiology. The current SGR formula, based as it is on changes in the gross domestic product, has proven unworkable essentially because changes in economic growth have little to do with the demand for medical services or the increasing cost of delivering them. If payments are cut in 2007, Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years. As recommended by MedPAC, the SGR should be replaced by a system that reflects increases in practice costs and other medical inflation variables.

Submitter : Ms. Susan McHugh-Salera **Date:** 08/28/2006

Organization : Mt. Sinai School of Medicine

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I am in full agreement of the rule changes that would grant advanced practice nurses (APNs) certified by NBCHPN reimbursement by Medicare.

APNs in hospice and palliative care draw from an extensive amount of experience and training when caring for patients and families dealing with life threatening illness. NBCHPN certified APNs are trained extensively in pathophysiology, symptom assesssment and management in addition to psycho-social support of patients and their families. Their services are essential in caring for this fragile population.

NBCHPN has ensured the validity of their examination and have proven its signifance. It is vital that Medicare give it's "blessing" to this growing field by including NBCHPN certified nurses on your list of providers.

Thank you.

Susan McHugh-Salera, MA, RN, PNP, ACHPN, AOCNP, CCRN
Palliative Care Nurse Practitioner
Clinical Coordinator, Palliative Care
Mt. Sinai Medical School
New York, New York

Submitter : **Dr. Oscar Penate** **Date: 08/29/2006**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

As an anesthesiology resident at the Cleveland Clinic and a member of the American Society of Anesthesiologists (ASA), I am writing today to ask that you take every possible action to prevent cuts in Medicare payments to physicians for 2007 by repealing and replacing the unfair SGR formula. As you know the current rule of relying on the GDP as an indicator of physician reimbursements is flawed because the demand for medical services is independent of economic growth. As the baby boomers near retirement the demand for anesthesia services will increase dramatically and cutting reimbursement for anesthesia services will severely affect patients who rely on these physicians to care for them.

Averting this crisis is more important now than ever because of new proposals released by CMS that would amount to a 10% cut in Medicare payment to anesthesiologists over the next four years. This proposed cut, on top of potential SGR-related reductions, could irreparably damage my specialty. If payments are cut in 2007, then Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years.

The american Society of Anesthesiology favors the update mechanism previously recommended by MedPAC, in which the SGR would be replaced by a system that reflects increases in practice costs and other medical inflation variables. For 2007, MedPAC has recommended a Medicare physician payment update of 2.8%.

Evidence is growing that anesthesiologists and other physicians are seeking practice settings where the need to provide care to Medicare beneficiaries is at a minimum. With a nationwide shortage of anesthesia providers, this trend suggests a looming access crisis for many Medicare beneficiaries to surgical, pain medicine and critical care services.

If you care about the american public and those who are or will be relying on medicare to receive medical care, I request that you work to fix the the flawed SGR formula and avert further devastating cuts to the medical specialty of anesthesiology. Your constituents-my patients-are counting on you.

Sincerely,

Oscar Penate, MD
3586 Northcliffe Road
University Heights, OH. 44118

206-276-5138

Submitter : Dr. Matthew Vo **Date:** 08/30/2006

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.
Anesthesiologists face a 10% cut in Medicare payment over the next four years due to changes in practice expense and work values. Potential SGR-related reductions, on top of further proposed cuts, could irreparably damage the medical specialty of anesthesiology.
The current SGR formula, based as it is on changes in the gross domestic product, has proven unworkable essentially because changes in economic growth have little to do with the demand for medical services or the increasing cost of delivering them.
If payments are cut in 2007, Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years.
As recommended by MedPAC, the SGR should be replaced by a system that reflects increases in practice costs and other medical inflation variables.

Submitter : Dr. Philippe Ball **Date:** 08/30/2006

Organization : Cleveland Clinic Foundation

Category : Physician

Issue Areas/Comments

Background

Background

The more reimbursement cuts are made the less likely private practise physicians will be inclined to perform anesthesia on medicare patients. Patients will have to go to state and government supported institutions, which themselves are underfunded and understaffed. The overall quality of health care for our elderly on medicare will continue to decrease as physicians have to curtail services in order to prevent losses. One example includes femoral nerve catheters, which have been shown to greatly decrease pain after total knee replacements, are so poorly reimbursed that placing one in a medicare patient is a financial loss and as such is foregone although it is generally seen as a standard of care and its utility proven by many studies. It is truly a shame that the United States proclaims itself to be one of the most advanced in many fields, including medicine, which it deems unimportant enough to support its financial future.

GENERAL

GENERAL

Dear Sir or Madam:

As an anesthesiology resident at the Cleveland Clinic and a member of the American Society of Anesthesiologists (ASA), I am writing today to ask that you take every possible action to prevent cuts in Medicare payments to physicians for 2007 by repealing and replacing the unfair SGR formula. As you know the current rule of relying on the GDP as an indicator of physician reimbursements is flawed because the demand for medical services is independent of economic growth. As the baby boomers near retirement the demand for anesthesia services will increase dramatically and cutting reimbursement for anesthesia services will severely affect patients who rely on these physicians to care for them.

Averting this crisis is more important now than ever because of new proposals released by CMS that would amount to a 10% cut in Medicare payment to anesthesiologists over the next four years. This proposed cut, on top of potential SGR-related reductions, could irreparably damage my specialty. If payments are cut in 2007, then Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years.

The american Society of Anesthesiology favors the update mechanism previously recommended by MedPAC, in which the SGR would be replaced by a system that reflects increases in practice costs and other medical inflation variables. For 2007, MedPAC has recommended a Medicare physician payment update of 2.8%.

Evidence is growing that anesthesiologists and other physicians are seeking practice settings where the need to provide care to Medicare beneficiaries is at a minimum. With a nationwide shortage of anesthesia providers, this trend suggests a looming access crisis for many Medicare beneficiaries to surgical, pain medicine and critical care services.

If you care about the american public and those who are or will be relying on medicare to receive medical care, I request that you work to fix the the flawed SGR formula and avert further devastating cuts to the medical specialty of anesthesiology. Your constituents-my patients-are counting on you.

Sincerely,

Dr. Philippe Ball
18111 Hillgrove Avenue
Cleveland, OH 44119
216-481-1010

Impact

Impact

There are no words to describe how utterly ridiculous the provisions are. The accountability used to determine the payment schedules are ludicrous and idiotic. The federal government has lost touch with the medical field in the areas of acceptable patient care and standards of care. If the government does not deem it necessary to fund standards of care, in many instances they will not be followed, opening the door for a regression in modern medicine as we know it.

Submitter : Mrs. Emily Gillum **Date:** 08/30/2006

Organization : Mrs. Emily Gillum

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Once again, the highly trained professionals who we all hope are available to us when we need medical care are being asked to provide their services for less money. As overhead to operate medical practices continues to increase, physicians are asked to maintain many demands by all payors, hospitals and the public, yet they are asked to take significant pay cuts. Congress votes pay raises for themselves. They tell the doctors (who they need and want the best of)to receive pay cuts. Most of the physicians provide extensive services for NO PAY to the indigent communtity. When insured people are cared for, they should be reimbursed appropriately for their services.

Submitter : Dr. David Louw **Date:** 08/30/2006

Organization : The Cleveland Clinic Foundation

Category : Physician

Issue Areas/Comments

Background

Background

Under the new medicare rules, academic anesthesiologist will diminish which will compromise the quality of new anesthesiologists. To ensure high quality training in the United States, we must not let this happen.

Submitter : **Dr. David Louw** **Date: 08/30/2006**

Organization : **The Cleveland Clinic Foundation / OSA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 29, 2006

CMS-1321-P 3
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1321-P
P.O. Box 8015
Baltimore, MD 21244-8015

Dear Sir or Madam:

As an anesthesiology resident at the Cleveland Clinic and a member of the American Society of Anesthesiologists (ASA), I am writing today to ask that you take every possible action to prevent cuts in Medicare payments to physicians for 2007 by repealing and replacing the unfair SGR formula. As you know the current rule of relying on the GDP as an indicator of physician reimbursements is flawed because the demand for medical services is independent of economic growth. As the baby boomers near retirement the demand for anesthesia services will increase dramatically and cutting reimbursement for anesthesia services will severely affect patients who rely on these physicians to care for them.

Averting this crisis is more important now than ever because of new proposals released by CMS that would amount to a 10% cut in Medicare payment to anesthesiologists over the next four years. This proposed cut, on top of potential SGR-related reductions, could irreparably damage my specialty. If payments are cut in 2007, then Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years.

The american Society of Anesthesiology favors the update mechanism previously recommended by MedPAC, in which the SGR would be replaced by a system that reflects increases in practice costs and other medical inflation variables. For 2007, MedPAC has recommended a Medicare physician payment update of 2.8%.

Evidence is growing that anesthesiologists and other physicians are seeking practice settings where the need to provide care to Medicare beneficiaries is at a minimum. With a nationwide shortage of anesthesia providers, this trend suggests a looming access crisis for many Medicare beneficiaries to surgical, pain medicine and critical care services.

If you care about the american public and those who are or will be relying on medicare to receive medical care, I request that you work to fix the the flawed SGR formula and avert further devastating cuts to the medical specialty of anesthesiology. Your constituents-my patients-are counting on you.

Sincerely,

David Louw, MD
Resident Delegate - Ohio Society of Anesthesiologists
Department of Anesthesiology, Critical Care Medicine, and Comprehensive Pain Management
The Cleveland Clinic Foundation
9500 Euclid Ave, E-30
Cleveland, OH 44195
216-444-2200

Submitter : **Dr. Paul Fiedler** **Date: 08/30/2006**

Organization : **Hospital of St. Raphael**

Category : **Physician**

Issue Areas/Comments

Impact

Impact

Regarding: Reassignment and Physician Self-Referral (pages 49054-49057)

Dear CMS Staff:

I fully endorse the language and intent of the proposed rules as outlined on page 49056. You note that you are "considering further amendments to 424.80(d) that would impose certain conditions on when a physician or medical group can bill for a reassigned PC of a diagnostic test." I strongly urge you to adopt the conditions as outlined. These conditions will ensure the integrity and independence of the pathology profession to the direct benefit of patients.

On the same page, you also note that you are soliciting comments on whether an anti-markup provision should apply to the reassignment of the PC of diagnostic tests. I believe that anti-markup language is vital to prevent the cannabilization of pathology by other subspecialties. Pathologists provide the quality assurance and quality control for the healthcare system. I once heard an internist remark that he can lie to lots of physicians, but not to a pathologist. Pathologists must remain objective and separate from financial conflicts of interest that may arise from contractual arrangements. Our referring physicains should not be able to profit from our hard work and expertise through markups.

Thank you so much for your thoughtful proposals.

If I can be of further assistance, please call me at 203-789-3073 or e-mail to fiedler@pol.net.

Yours truly,

Paul Fiedler, MD
Atttending Pathologist
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06515

Submitter : Mr. John R. Celestino **Date:** 08/30/2006

Organization : Whitworth Physical Therapy P.S.- Valley Clinic

Category : Physical Therapist

Issue Areas/Comments

Background

Background

Reduced and limited medicare enrolles to physical therapy programs

GENERAL

GENERAL

Please contact me if you wish at 1-509-242-1272 or e-mail at
john@whitworthpt.com regarding this proposal and the effect it will have the limiting and restricting access to physical therapy services for our deserving elderly.

Impact

Impact

decreasing payment by and effective 10% over the next 5 years to physical therapists treating Medicare recipients

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I am and geriartic clinical specialist (physical therapist) who has been treating the elderly for 26 years and will notice and reduction in their services and ease of access.

Submitter : Dr. Sandeep Sherlekar **Date:** 08/30/2006

Organization : CAPMA

Category : Physician

Issue Areas/Comments

Background

Background

we are already suffering a shortage of anesthesia providers and reimbursement drops will push people into other fields. We are not compensated for the time and effort we put into the practice and we would expect to be compensated fairly. With the malpractice crisis in this state we have been forced into a further critical shortage and only decent reimbursement can make up for it other than tort reform

Submitter : Dr. harold Goll **Date:** 08/30/2006

Organization : Greater Baltimore Medical Center

Category : Physician

Issue Areas/Comments

Background

Background

This will steeply reduce the availibility of care to the elderly. The payments are already well below market (75%). Reducing anesthesia payment further will result in people not participating in medicare, and thus not caring for the elderly in acute care hospitals. This is crazy.

Submitter : Dr. kenneth backstrand **Date:** 08/30/2006

Organization : asa

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I encourage you to cut physician reimbursements. Doing so will result in a massive MD dropout from the Medicare program thus forcing appropriate increases which are desperately needed. I LOSE money on any Medicare patient since my CRNA's demand higher hourly wages than Medicare pays me. Only by creating a crisis will significant changes be made. The rest of the ASA are sending you letters groveling for a 1 or 2 percent increase. This will not help at all. Only a 20 or 30 percent increase will help and that won't happen without a crisis. Therefor I encourage you to drop our payments to create such a crisis. Thank you. Kenneth Backstrand, MD

Submitter : **Dr. Edward Mauricio Noguera Chia** **Date: 08/30/2006**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Background

Background

To cut in 10% Medicare payments to physicians over the next four years.

GENERAL

GENERAL

August 30th, 2006

CMS-1321-P 3
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1321-P
P.O. Box 8015
Baltimore, MD 21244-8015

Dear Sir or Madam:

I chose the field of medicine to help others grow and live longer and I am hoping that our government helps me and my collegue anesthesiologists achieve this goal. I am an anesthesiology resident at the Cleveland Clinic. Everyday that passes by in my residency training, I can easily see the shift of the medical practice: I see more and more baby boomers coming to surgery everyday with the hope of staying healthy, with the hope of seeing this great nation evolve. They were the foundation and the example for my life and I own them respect and consideration, thus, today, as a member of the American Society of Anesthesiologists, I am writing to you for you to kindly consider to take every possible action to prevent cuts in Medicare payments to physicians for 2007 by repealing and replacing the unfair SGR formula. As you know the current rule of relying on the GDP as an indicator of physician reimbursements is flawed because the demand for medical services is independent of economic growth. As the baby boomers near retirement the demand for anesthesia services will increase dramatically and cutting reimbursement for anesthesia services will severely affect patients who rely on these physicians to care for them.

Averting this crisis is more important now than ever because of new proposals released by CMS that would amount to a 10% cut in Medicare payment to anesthesiologists over the next four years. This proposed cut, on top of potential SGR-related reductions, could irreparably damage my specialty. If payments are cut in 2007, then Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years.

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Evidence is growing that anesthesiologists and other physicians are seeking practice settings where the need to provide care to Medicare beneficiaries is at a minimum. With a nationwide shortage of anesthesia providers, this trend suggests a looming access crisis for many Medicare beneficiaries to surgical, pain medicine and critical care services.

If you care about the american public and those who are or will be relying on medicare to receive medical care, I request that you work to fix the the flawed SGR formula and avert further devastating cuts to the medical specialty of anesthesiology. Your constituents-my patients-are counting on you.

Sincerely,

Edward M Noguera, MD
1583 Holmden Road
South Euclid, OH 44121
Phone # 2162970111

Impact

Impact

Proposed rule is unfair and projections show that if payments are cut in 2007, then Medicare physician payment rates will have fallen 20 percent below the government s conservative measure of inflation in medical practice costs in just six years.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Impact over the quality of life of our fellow americans especially the elderly.

Submitter : Dr. Kevin Haim **Date:** 08/31/2006

Organization : Dr. Kevin Haim

Category : Physician

Issue Areas/Comments

Background

Background

The continued cut in anesthesia reimbursement will decrease the services available to our most valued assets our senior citizens.

GENERAL

GENERAL

Anesthesia costs continue to rise and the average per hour medicare reimbursement continues to decrease. Medicare reimbursement for anesthesia is the lowest of all medical specialties. Medicare pays anesthesia on average less than $60/hour of anesthesia.

Submitter : **Dr. mona kanda** **Date: 08/31/2006**

Organization : **Cleveland Clinic Department of Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

As an anesthesiology resident at the Cleveland Clinic and a member of the American Society of Anesthesiologists (ASA), I am writing today to ask that you take every possible action to prevent cuts in Medicare payments to physicians for 2007 by repealing and replacing the unfair SGR formula. As you know the current rule of relying on the GDP as an indicator of physician reimbursements is flawed because the demand for medical services is independent of economic growth. As the baby boomers near retirement the demand for anesthesia services will increase dramatically and cutting reimbursement for anesthesia services will severely affect patients who rely on these physicians to care for them.

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Sincerely,

Mona Kanda, MD
740 W. Superior Ave., #705
Cleveland, OH 44113
216-298-4468