Submitter : **Ms. Sally Fox** **Date: 09/16/2006**

Organization : **St. Mary's Health Center**

Category : **Other Practitioner**

Issue Areas/Comments

Impact

Impact

I'd like to express my strong support in regards to adding the National Board for Certification of Hospice and Palliative Nurses to the list of national certifying bodies that are recognized by Medicare as being appropriate for certification of advanced practice nurses (NPs and CNSs). The NBCHPN is a well established, reputable board which was originally partnered with the ANCC and has maintained the same level of professionalism and quality since it became sole proprietor in 2005. Thank you for addressing this matter.

Attachment
179

Ear, Nose and Throat Associates of S. Florida
900 NW 13th Street #206
Boca Raton, Florida 33486

E mailed to expedite delivery. Original letter went DHL overnight 9/15/06

September 13, 2006

CMS
Washington, D.C.

RE: CMS1321-P
Medicare Program revision to payment policies under the physician fee schedule for calendar year 2007 and other changes to payment under Part B

Dear Sirs:

I am a physician in Boca Raton, Florida. I am a member of a large otolaryngology group and upcoming President of the Florida Society of Otolaryngology. I am writing this letter with concern regarding the proposed ruling. I have become aware of the issue and feel that it is a mistake and would have many onerous and unintended results.

Firstly, there is concern that although intended to affect the results and distribution of funds following results of pathologic studies, there is nothing to prevent this rule change from applying to

other ancillary services and would have a great and broad effect on many arrangements already in place. In addition, rules that are already in place to protect patients from over utilization are extremely complex and this proposal will add to the complexity and confusion regarding proper application of these rules.

Regarding the rules in particular, "Pod Labs" have only anecdotal allegations by the ACP (American Clinical Pathologists) regarding their concerns for over utilization. These concerns are that Pod Labs will result in unnecessary biopsies. This is an assumption not backed by study. Clinical studies to date indicate that if anything, inadequate biopsies are being performed and that dangerous diagnoses are being missed in those not evaluated. ACP arguments appear to be disingenuous and self-serving. It is the pathologist that will benefit financially from this new arrangement. The Congress and government should not be expected to protect "the turf" of any specialty or subspecialty versus another. There is no compelling data that these rule changes are necessary to prevent program abuse.

In virtually every scenario it is true that the costs of the program are actually driven by the pathologists and not the clinicians. Pathologists use a number of studies/stains per biopsy and costs are directly related to

this development. The number of biopsies is only marginally related to the ultimate cost. More biopsies result in an additive increase, but more studies for each biopsy result in a multiplication of cost increase.

I question the fairness of changing complex and often misunderstood rules. It seems that this change clearly is intended to benefit one group of physicians over another. Any change in rules should apply fairly across the board and have valid cost saving and clinical data to support them.

Phase II regulations published in July of 2004 already contains specific well considered provisions to permit the sharing of facilities where ancillary services by practices located in the same building. Acting on this mandate, many physicians have already set up effective medical office buildings in which ancillaries are appropriately shared and result in cost effective sharing of these services. It also increases patient convenience and increases the rapidity in which diagnoses are obtained. It reduces the chance of diagnostic omissions for lack of appropriate studies. These new proposed regulations would intentionally create unnecessary overhead and complexity facing patients in getting their diagnosis following a biopsy.

Based on the foregoing arguments, I believe that CMS should do the following: First they

should review the level of compensation enjoyed by pathologists as this is driving the profitability of histology and pathology practices and fueling the current issue. The current CMS methodology should be reviewed for potential abuses by histologists and pathologists. An independent study should determine whether urologists who own Pod Labs or any other type of histology service in fact perform more biopsies. Until this type of practice is established, there can be no credible response. It is our belief that findings of this study would not show abuse. The concept of purchased professional services should be either eliminated or left as is, and finally, as physicians we need additional practical guidance in the creation of "same building shared ancillary services".

I send this letter with confidence that you will act upon it appropriately. As demonstrated, I have great concern regarding the consequences of any rule change, both on the present issue and in my ability to service my patients with appropriate ancillary services in general.

Respectfully submitted,

Mark H. Widick, M.D.
MHW/jlg

Submitter : **Date: 09/17/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 11, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: Physician Fee Schedule Rule# CMS-1321-P

Dear Administrator:

Thank you for the opportunity to provide comments about the Centers for Medicare and Medicaid Services proposed rule #CMS-1321-P that was published in the Federal Register on August 23, 2006. This letter is written to share my perception of the proposed reduction in professional fees for radiation / oncology brachytherapy services.

Access to Brachytherapy is critical. The reduction CMS is proposing will have a detrimental impact on my ability to offer the Brachytherapy / Partial Breast Irradiation Therapy treatment option to my Medicare patients.

Brachytherapy allows the radiation process to move quickly so that other treatments such as chemotherapy can be started in a timely fashion. The preparation and effort for treatment planning is quite time consuming. Proper catheter placement must be confirmed before each fraction is given. The CMS proposed reduction to all brachytherapy codes, especially CPT 77781, will not adequately cover the time and involvement required to prepare a patient for brachytherapy. If the reduction does take place, CMS will be limiting access to brachytherapy for Medicare patients.

With the prevalence of breast cancer, I urge CMS to reconsider the proposed Work RVU reduction for brachytherapy. Please leave brachytherapy codes as they currently stand, and, if needed, make a reduction to the conversion factor. I appreciate your careful review and analysis of this important matter. I strongly urge CMS to reconsider the significant, negative impact that would result from the proposed reductions.

Sincerely,

Sandra E. Mitchell, M.D.
Piedmont Radiation Oncology, P.A.
Forsyth Regional Cancer Center

cc: Representative Sue Myrick, Energy and Commerce Health Subcommittee, Co-Chair, House Cancer Caucus

Senator Richard Burr, Senate Health, Education, Labor and Pensions Committee

Carol Bazell, MD, MPH, Director, Division Outpatient Services

Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation and Oncology (ASTRO)

James Rubenstein, MD, Chairman, American College of Radiation Oncology (ACRO)

W. Robert Lee, MD, President, American Brachytherapy Society (ABS)

Submitter : **Date: 09/17/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 11, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1321-P - Rule: Physician Fee Schedule

Dear Administrator,

Thank you for allowing me the opportunity to provide comments on file #CMS-1321-P for the CY 2007 / 2008 CMS proposed Physician Fee Schedule Rule. I have some serious concerns regarding your proposed changes.

At Forsyth Hospital, we take pride in the services offered to Medicare beneficiaries. We are extremely professional and pay a lot of attention to detail. We are very adept in administering brachytherapy services, but the proposed reduction in RVUs from 0.53 down to 0.33 will impede my ability to provide brachytherapy treatments to Medicare patients.

In calculating my time, brachytherapy constitutes the following:

CT Simulation

Planning

Check each simulation film

Check for infection, confirm antibiotics, check for allergies

Treatment itself time will vary depending on the source

Removal of the balloon / wound dressing

Medicare patients deserve the right to have access to brachytherapy services. CMS must preserve the work RVU on the professional side for Medicare patients to continue to have this procedure available.

Thank you for heeding these recommendations. We would like to continue servicing our Medicare patients.

Lisa S. Evans, MD
Piedmont Radiation Oncology, PA
Forsyth Regional Cancer Center

cc: Representative Sue Myrick, Energy and Commerce Health Subcommittee, Co-Chair, House Cancer Caucus

Senator Richard Burr, Senate Health, Education, Labor and Pensions Committee

Carol Bazell, MD, MPH, Director, Division Outpatient Services

Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation and Oncology (ASTRO)

James Rubenstein, MD, Chairman, American College of Radiation Oncology (ACRO)

W. Robert Lee, MD, President, American Brachytherapy Society (ABS)

Submitter : **Amgad Hanna** **Date: 09/17/2006**

Organization : **CLeveland Clinic Foundation**

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 :

Date: 09/18/2006

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

September 11, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1321-P; Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment under Part B

Dear Administrator / CMS:

Thank you for the opportunity to provide comments on file #CMS-1321-P for CMS proposed Physician Fee Schedule changes. I currently bill CPT codes 19296 & 19297 when clinically indicated for Medicare beneficiaries.

CPT codes 19296 & 19297 refer to the Mammosite Partial Breast Irradiation Therapy procedure. Mammosite is a balloon catheter device that is used to deliver a radiation seed (two times per day for five days) exactly where the radiation needs to be. We are treating the disease closest to the tumor bed where the patient is at greatest risk for breast cancer recurrence.

Partial Breast Irradiation Therapy is of particular importance for Medicare age woman. Breast Cancer is prevalent in this age population and radiation therapy is extremely necessary to prevent recurrence of disease.
It is imperative that radiation therapy begin as quickly as possible, but with standard radiation modalities, many Medicare age women do not complete their 6-8 weeks of Radiation Therapy. The National Cancer Institute reports that an estimated 25% of women who opt for breast conservation treatment (lumpectomy) do not receive radiation therapy which significantly increases their risk for recurrence. A five-day radiation treatment option would increase compliance and thus reduce the risk of recurrence.

If CMS moves forward with proposed Physician Fee Schedule reductions with the RVUs associated with 19296 & 19297 for site of service 11, CMS will limit access to the partial breast irradiation therapy treatment option. With the proposed reductions, many Surgeons and Radiation Oncologists will no longer be able to offer Breast Conservation Surgery with Partial Breast Irradiation Therapy to your Medicare patients. I am requesting that CMS please not lower the RVUs associated with CPT codes 19296 & 19297 or the RVUs associated with Radiation Therapy regarding this procedure in relation to the Global Fee Schedule.

Again, I appreciate the opportunity to comment on file #CMS-1321-P. I strongly urge CMS to reconsider the proposed changes and keep the current RVUs in place so that Medicare patients may continue to have this very important treatment option.

Thank you in advance for your assistance,

David R. Carr, MD, FACS

cc: Representative Sue Myrick, Energy and Commerce Health Subcommittee, Co-Chair, House Cancer Caucus

Senator Richard Burr, Senate Health, Education, Labor and Pensions Committee

Carolyn Mullen, Deputy Director, Division of Practitioner Services

Boyd Honeycutt, Carrier Medical Director, Part-B, Cigna Government Services

Helen Pass, MD, FACS, President, American Society of Breast Surgeons

Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

CMS-1321-P-183-Attach-1.DOC

Attach
183

September 11, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1321-P; Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment under Part B

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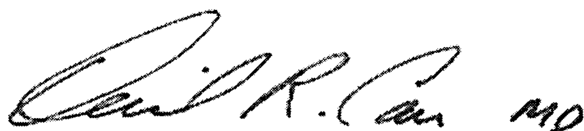
Again, I appreciate the opportunity to comment on file #CMS-1321-P. I strongly urge CMS to reconsider the proposed changes and keep the current RVUs in place so that Medicare patients may continue to have this very important treatment option.

Thank you in advance for your assistance,



David R. Carr, MD, FACS

cc: Representative Sue Myrick, Energy and Commerce Health Subcommittee, Co-Chair, House Cancer Caucus

Senator Richard Burr, Senate Health, Education, Labor and Pensions Committee

Carolyn Mullen, Deputy Director, Division of Practitioner Services

Boyd Honeycutt, Carrier Medical Director, Part-B, Cigna Government Services

Helen Pass, MD, FACS, President, American Society of Breast Surgeons

Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : Dr. Richard Fairley **Date:** 09/18/2006

Organization : Dubuque Internal Medicine

Category : Physician

Issue Areas/Comments

Background

Background

We can not sustain increasing cuts in payments while costs continue to rise. It is impossible. I know you think your hands are tied unless there is Congressional action but please do whatever you can to prevent this 5.1% decrease in physicians' payment from taking affect. Hey, Hey, Ho, Ho, the SGR has got to go!

GENERAL

GENERAL

See impact statement

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

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

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

Submitter : **Mr. Gerard Bieker** **Date: 09/18/2006**

Organization : **Cardiovascular Consultants of KS, PA**

Category : **Physician**

Issue Areas/Comments

Background

Background

The 5.1% 2007 planned Medicare Fee Schedule reductions will have a negative impact on office operations. Because of reductions over the last decade plus period of time we're already finding it hard to hired qualified individuals to work in this industry. In addition physician salaries have continued to decline to a point were medical students are not electing to work in cardiology the second most demanding fields to practice in. So please stop the planned payment reductions. You surely don't expect your employees to work for 5.1% less next year than this year? Are you going to work for 5.1% less?

GENERAL

GENERAL

The 26% Medicare reductions planned over the next 5 to 6 years makes no sense. You have to know that commercial carriers follow what Medicare does. I fear the preventative nature of medicine in the field of cardiology will be lost if the foolishness of all these proposed cuts doesn't get some common sense behind it. This is my 16th year in the medical field and I can assure you our physicians are earning much less than they were sixteen year ago. If you want to cut various procedures out at certain ages that's one thing but don't punish the docs & employees who can provide those to services to the elderly.

Submitter : Dr. Felix Angel Rodriguez-Pinero **Date:** 09/18/2006

Organization : Hem & Med Onc S Palm Beach County

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,

I am a medical oncologist within a four person single-specialty, private practice group. Pertaining to the issue of "pod labs", your allegation is that these labs will induce health practitioners, specifically urologists, to perform unnecessary procedures and order unnecessary studies so they can profit from them.

The proposed regulations have an emphasis where they appear to favor the American College of Pathologists. Perhaps the only real concern is that pathologists may no longer find themselves solely in control of of the ridiculously profitable histology/patholgy industry.

No serious argument can be made that surgeons are taking biopsies so that they can overutilize pathology. In fact, most studies reflect that surgeons should be taking more samples from more sites to fulfill the appropriate standard of care. Besides, in almost every scenario costs to the Medicare Program are driven by pathologists, not by the clinician (the pathologist determines the type and number of studies performed on a given sample).

The effect of the ruling would be to reduce compensation for the physicians actually taking care of Medicare beneficiaries. In turn, this compensation would be increased for practitioners who never see these patients. Furthermore, these proposed regulations would intentionally create unnecessary overhead by proposing minimum square footage, limitations on the number of practices in the "same building" and using the same subspecilists, requiring no-physician personnel for at least 35 hours per week regardless of productivity, and requiring "permanent" equipment.

Shared ("pod lab") facilities are cost effective and convenient to patients, and actually limit repetitive labs over given periods of time.

We believe CMS should:
1. review the level of compensation enjoyed by pathologists presently;
2. review the profitability of histology/pathology practices presently;
3. review the potential for abuse caused by the present CMS payment methodology for histology/pathology, where pathologists are freely permitted to profit directly by performing multiple studies (stains) on the same specimen;
4. eliminate or leave as at present the concept of "purchased professional services"; and
5. provide additional, practical guidelines on creation of "same building shared ancillary services".

Thank you for your kind attention in this matter.

Sincerly,

Dr. Felix Angel Rodriguez
Hematology and Medical Oncology of Southern Palm Beach County
2623 S. Seacrest Boulevard
Ste 216
Boynton Beach, Florida 33435

Submitter :

Date: 09/18/2006

Organization :

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

I encourage you to include Radiology in the proposed changes to the reassignment rules. Radiology has long suffered from self-referral abuses. Specifically, the suggestions that 1. Physicians or groups billing the interpretation of a diagnostic test must also perform the technical component, 2. Those physicians who interpret are not also treating the patients and 3. The ordering physician must be financially independent of the physician performing the diagnostic test and interpreting the diagnostic test taken in combination would in effect eliminate the current financial incentives found with self-referral. Medicare recipients would benefit by not undergoing unncessary and expensive diagnostic tests that may be of lesser quality. It's important to remember that imaging examinations frequently expose the patient to radiation. Radiologists are the only physicians trained in the proper use of this equipment, the calibration of this equipment in order to minimize radiation exposure, and the interpretation of these examinations. We have repeatedly seen quality and appropriateness issues with examinations perfomed by physicians not specifically trained in diagnostic radiology. Research has shown that the number of imaging examinations ordered by physicians with in-office equipment is significantly higher than by those physicians who refer patients to outside facilities.

Impact

Impact

Radiology should be included in the reassignment rules.

Submitter : **Mrs. MARLEEN POPOVIC** **Date: 09/18/2006**

Organization : **ILLINOIS ONCOLOGY,LTD**

Category : **Nurse**

Issue Areas/Comments

Background

Background

I am a practice administrator of a 4 physician oncology practice- considering the cuts that oncology has already experienced ,another 5.1% decrease could have serious repercussions for our patients. Paient's without seconday coverage/ poor coverage may not be able to have access to treatment since a practice cannot afford to carry this amount of debt.Our drug prices continue to rise while all other reimbursement declines. Plus oncology is top heavy with nursing salaries which due to the nursing shortage also continue to rise.Patient's will soon be forced to receive treatment in a hospital setting if these decreases are implemented. I am very confused as to how decreasing our payments will encourage our suppliers to hold down costs- PHYSICIANS END UP BEING THE ONLY ONES FORCED TO TAKE CUTS-every day I receive a notice re a price increase on a chemotherapy drug- what are you doing to control this? Just as ASP + 6 is not accurate so will this fee schedule end of being more than a 5.1 decrease. I hope you will reconsider this rule. Thank you

CMS-1321-P-189

Submitter :

Date: 09/18/2006

Organization :

Category : **Physician**

Issue Areas/Comments

Background

Background

I work in a large family practice. The reduction in reimbursement for DEXAs will make it more difficult to upgrade our machine to keep pace with technology. Currently, it is utilized a little less than 50% of the day. Lower reimbursement will make it less desirable to do in-office and will reduce availability to Medicare patients.

Submitter : Dr. MORTON H. FIELD

Date: 09/18/2006

Organization : MORTON H. FIELD, M.D.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTATCHMENT

CMS-1321-P-190-Attach-1.PDF

Attach #
190

CMS-1321-P Issue Identifier = Independent Diagnostic Testing Facility (IDTF) Issues.

3. Supervision

The proposed revision of π410.33(b)(1) is inappropriate in the case of imaging centers (IDTF) for the following reasons:

A) This proposed limitation is unnecessary because the "supervision" in imaging IDTF is not a real time endeavor because the supervising physician must use the imaging document to create an interpretation (report) which must be stored indefinitely for later documentation if requested. If the image is unsatisfactory, no responsible, ethical radiologist will provide a reading or if done, without a comment on the partial or complete inadequacy of the image.

Currently, most IDTF's create, read and store hard copy images, but the trend is increasing to employ and provide offsite digital images which can be read in realtime any place in the world. In this case, if the image is partially or completely unreadable, it will be medically unusable, unbillable and unreimbursable. In this scenario, a radiologist (board certified) can read images from any number of IDTF's, limited only by his/her ability to keep up with the work flow. This trend is progressing so rapidly that the costs of the scanning equipment are plummeting. This modality will be in use in over 60% of images read in the next two years.

This is in contradistinction to chemical and similar laboratory tests in which the result is totally dependent upon the methodology used and which must be observed while being processed (created) as the only way to verify its accuracy and reliability, and which are verified against known samples (proficiency testing) to verify the methodology and performance of the tests.

The number of radiologists currently available to "supervise" an imaging IDTF is very limited. To limit the number of entities that can be supervised by one radiologist (under the current definition) is to severely restrict access to imaging services. Alternately, the planned restriction will force the IDTF to search for and resurrect retired, obsolete or substandard radiologists to supervise (and read) the services at great peril to the beneficiary.

The new regulation "π410.33(b)(1)" should be modified to allow only currently licensed board certified radiologists to "supervise" imaging only IDTF's as opposed to the supervision of other or mixed service IDTF's.

Additionally, the current trend is for imaging entities to have contracts with imaging groups containing many radiologists because of the increasing need for realtime 24/7 imaging results. Under these

CMS-1321-P Issue Identifier = Independent Diagnostic Testing Facility (IDTF) Issues.

3. Supervision

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The new regulation "π410.33(b)(1)" should be modified to allow only currently licensed board certified radiologists to "supervise" imaging only IDTF's as opposed to the supervision of other or mixed service IDTF's.

Additionally, the current trend is for imaging entities to have contracts with imaging groups containing many radiologists because of the increasing need for realtime 24/7 imaging results. Under these

circumstances no single radiologist could or should be designated as the "supervising" person. Rather a definition of a group or entity containing only licensed certified radiologists should be defined as a proper "supervising" entity.

Submitter : Dr. John Shook

Date: 09/18/2006

Organization : Saint Luke's Cancer Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1321-P-191-Attach-1.DOC

Attach #
191

September 18, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator:

Thank you for allowing me the opportunity to offer my comments on The Centers for Medicare and Medicaid Services' proposed rule, as was recently published in the Federal Register on August 22, 2006. Specifically, I am concerned regarding the proposed RVU reduction for CPT19296, performed in office globally, over the next several years.

The changes as proposed would have a significant impact on my practice, and particularly on the treatment options I would be able to present to my breast cancer patients. Access to partial breast irradiation (PBI) is an important option for my patient population. Unfortunately, if the proposed reduction takes place, I may no longer be able to provide PBI to my Medicare patients; effectively limiting access to treatments for this disease. As a result, my Medicare patients may be forced to schedule services at the hospital instead, which will add a greater cost to the Medicare system, as well as impede quick access and scheduling for patients with a confirmed diagnosis of breast cancer. In anticipation of the proposed reduction of the conversion factor by 5.1%, CMS' proposal, to then also cut RVU's will affect my ability to offer Medicare patients appropriate care in my office.

As a physician focusing on breast cancer treatment, I urge CMS to reconsider the proposed RVU reductions. Please leave the RVU's assigned to CPT 19296 as they currently stand. I appreciate your careful consideration and strongly urge CMS to reconsider the significant impact the proposal outlines.

Sincerely,

John W. Shook, MD
4323 Wornall Road
Kansas City, MO 64111
816-932-2836

cc. Senator Jim Talent, Senate Cancer Coalition
Carolyn Mullen, Deputy Director, Division of Practitioner Services
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Dr. John Shook** **Date: 09/18/2006**

Organization : **Saint Luke's Cancer Institute**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1321-P-192-Attach-1.DOC

Attach# 192

September 18, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

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4323 Wornall Road
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816-932-2836

cc. Senator Jim Talent, Senate Cancer Coalition
Carolyn Mullen, Deputy Director, Division of Practitioner Services
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter :

Date: 09/19/2006

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

xx

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 : Luanne Lange

Date: 09/19/2006

Organization : Hunterdon Hematology Oncology

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

CMS-1321-P

The impact will be that more Community Oncology Office will dissolve because we will not be able to afford giving away care to the patients. More patients will be treated in the hospital costing Medicare even more money.

GENERAL

GENERAL

As the Practice Manager for a Community Cancer Center I find the proposed cut to the Physician Fee Schedule adds insult to injury. The Societies that support Oncology have already shown to Congress that the Physician Fee Schedule does not support the work that is performed in the clinic. With the drug reimbursement cut to the point where we can just pay for the drugs it is not possible to support the center expenses. There are many drugs where we do not break even! We need to have the Physician Fee Schedule at least support the work and materials needed to give adequate care to the patients. I suggest that Medical Oncology be regarded as a separate entity and not grouped in with Family Practice rules as we operate entirely different from other medical fields. Please do further research in this matter before enacting on this.

Submitter : **Yudi Steinfeld** **Date: 09/19/2006**

Organization : **Imperial Care Center**

Category : **Long-term Care**

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 : **Rebecca Knight** **Date: 09/19/2006**

Organization : **Foothills Surgical Associates, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 14, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1321-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment under Part B

Dear Administrator:

Thank you for allowing me the opportunity to provide comment on the Centers for Medicare and Medicaid Services proposed rule (CMS-1321-P), published in the Federal Register on August 22, 2006.

By reducing the RVU s for CPT 19296, CMS will significantly limit the number of Medicare beneficiaries who will receive this important procedure in my office. As a result, many Medicare beneficiaries will have to schedule this procedure in the hospital, which will burden the Medicare system with unnecessary costs, as well as impede/delay the treatment process of Medicare beneficiaries diagnosed with breast cancer. These patients must undergo catheter implantation and radiation therapy as quickly as possible.
In order for me to continue to provide access and availability of this procedure in my office for Medicare beneficiaries, I am requesting that CMS stabilize or freeze the current RVU s for CPT 19296.

Thank you for your careful consideration of the impact your decision will make on Medicare beneficiaries with regard to access to this very important procedure in the treatment of breast cancer. I urge you to reconsider your proposal or run the risk of severely limiting access to partial breast irradiation for Medicare beneficiaries.

Sincerely,

Rebecca Knight, MD

Rebecca Knight, MD
Foothills Surgical Associates, PC
3555 Lutheran Pkwy., Ste. 380
Wheat Ridge, CO 80033
(303) 940-8200

Cc: Representative Diana DeGette, Energy and Commerce Health Subcommittee
Carolyn Mullen, Deputy Director, Division of Practitioner Services
Helen Pass, MD, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : Dr. Cheryl Stanski

Date: 09/19/2006

Organization : Holston Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1321-P-197-Attach-1.DOC

Attach#
197

September 18, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1321-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment under Part B

Dear Administrator:

Thank you for allowing me the opportunity to provide comment on the Centers for Medicare and Medicaid Services' proposed rule, published in the Federal Register on August 22, 2006. This letter is written to share my concern regarding the proposed RVU reduction for CPT 19296, performed in-office, over the next few years.

With a breast cancer diagnosis, it is imperative the tumor is removed and radiation therapy start as quickly as possible. Partial breast irradiation (PBI) allows this process to move very quickly so that other treatments (chemotherapy) can be started as well. Unfortunately, if the proposed reduction takes place, I may no longer be able to provide PBI to my Medicare patients; therefore limiting access to treatments for this deadly disease. As a result, my Medicare patients may be required to have services scheduled at the hospital which will add a greater cost to the Medicare system.

As a practitioner focusing on breast cancer treatment, I urge CMS to reconsider the proposed RVU reductions. Please leave the RVU system as is. I appreciate your careful consideration and review in this important matter and strongly urge CMS to reconsider the significant impact the proposal outlines.

Sincerely,

Cheryl A. Stanski, MD

Cheryl A. Stanski, MD
Holston Medical Group
2204 Pavilion Drive
Kingsport, TN

cc. Senator Bill Frist, Majority Leader Bill Frist
Carolyn Mullen, Deputy Director, Division of Practitioner Services
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons