**Submitter :** Dr. Joseph Cirrone **Date:** 09/21/2006

**Organization :** North Shore Radiation Oncology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-1321-P-250-Attach-1.DOC

Attach #
250

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 reduction in professional fees for radiation/oncology brachytherapy services.

CMS has proposed drastic cuts in th RVUs assigned to the global fee schedule for HDR breast brachytherapy. They are scheduled to reduce by 20% each year in the transition period and the total reduction for this treatment is -55% as illustrated in the table below.

| CPT Code | Description | Units | 2006 RVU | 2006 Average Rate | 2010 RVU | Variance 2010 to 2006 | Variance 2010 to 2006 |
|---|---|---|---|---|---|---|---|
| 99245 | office consult, comprehensive | 1 | 5.91 | $224 | 6.25 | $1 | 0% |
| 77263 | physician treatment planning, complex | 1 | 4.41 | $167 | 4.16 | ($18) | -10% |
| 77470 | special treatment procedure | 1 | 14.64 | $555 | 4.55 | ($391) | -71% |
| 76370 | CT for planning | 1 | 4.29 | $163 | 5.48 | $35 | 21% |
| 77370 | special medical physics consult | 1 | 3.68 | $139 | 2.51 | ($49) | -35% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 77290 | simulation, complex (contour volumes) | 1 | 9.02 | $342 | 15.22 | $206 | 60% |
| 77326 | Brachytherapy isodose plan | 1 | 3.78 | $143 | 3.89 | ($3) | -2% |
| 77300 | dose calc | 10 | 2.26 | $856 | 1.80 | ($209) | -24% |
| 77336 | weekly medical physics consult | 1 | 3.15 | $119 | 1.08 | ($81) | -67% |
| 77280 | simulation, simple | 5 | 4.62 | $875 | 5.27 | $72 | 8% |
| 77781 | Afterloading HDR brachy (1-4 source positions) | 10 | 23.69 | $8,978 | 6.58 | ($6,611) | -74% |
| | | | | | | ***($7,049)*** | ***-56%*** |

*NOTE: 2006 CF is $37.8975 with assumption for 2010 using proposed CF of $35.9647; applicable to Physician Fees*

The alternative radiation treatment is Whole Beam External Radiation Therapy (WBXTR) where women must endure 6 weeks of radiation. Alternatively, the RVUs for WBXRT increase by 55% or $6,000 during the transition period and will be reimbursed at a proposed rate of more than $9,000 than HDR Breast Brachytherapy. This treatment is extremely beneficial for the patient in that it irradiates less healthy tissue and allows them to return back to their life activities in just five days, however, HDR breast brachytherapy does require more time for the radiation oncologist to plan, calculate and treat with HDR breast brachytherapy. These proposed cuts in RVUs are insufficient to cover the cost and time required to administer HDR breast brachytherapy and will result in the limiting access to this radiation treatment for women who are Medicare beneficiaries.

There are several RVUs that are decreasing by more than 5%. I recommend that CMS implement a floor of 5% reduction and this floor should remain in effect during the required time for CMS and the RUC to re-evaluate the data applicable to these RVUs, specifically, HDR breast brachytherapy. I am willing to provide data to my specialty society so that they may in turn provide the necessary data to CMS and the RUC in order to make a more informed proposal in the readjustment of these RVUs applicable to HDR breast brachytherapy.

Sincerely,

*Joseph S. Cirrone, MD*
181 Belle Meade Rd
Suite One
E. Setauket, NY 11733

CC Senator Hillary Clinton, Senate Health, Education, Labor and Pensions Committee

James Rubenstein, MD Chairman James Rubenstein, MD, Chairman, American College of Radiation Oncology

**Submitter :** Mrs. Nicole Heldt **Date:** 09/21/2006

**Organization :** Bay Park Community Hospital

**Category :** Other Technician

**Issue Areas/Comments**

**Impact**

Impact

Comments on Proposal:Practice Expense, DRA fees

I am a Radiographer who performs Dexas on a daily bases. I am against the above Proposals
Dexa was recently added as a preventative service, cuts go against medicars own initiative to increase the utilization. Dexa is a preventiative service that need more recongnition to prevent bone loss in all patients. It is underutilized and need more advertising to help prevent bone fractures, such as hip fractures that will inturn cost medicare more money.
We are currently looking at putting in a Dexa Scanner in several off sites, but due to the potential reimbursement drop in these exams, physicans as well as the hospital will rethink these options with great concideration.

**Submitter :** Dr. Allan Clemenger **Date:** 09/21/2006

**Organization :** Allan Clemenger, M.D., LLC

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

42101 N 41st Drive, #124
Anthem, AZ 85086
September 21, 2006

Allan K. Clemenger, M.D., L.L.C.
Attention Medicare:
RE: Document #1321-P ; Coverage of Bone Mass Measurement (BMM) Tests
As a Gynecologist who has been in clinical practice for over 40 years I see many women in their post-menopausal years. All these patients are at risk for Osteoporosis with its attendant risks of spine and hip fracture which are at the least disabling and at most lethal. Prevention of this condition is now quite possible medically if the individual is followed with serial bone mineral density scans. In view of this I feel no changes should be considered as to reimbursement for Bone Mineral Dexatometry. Should the reimbursements be cut as proposed it would be very difficult for me to continue to spend the time involved performing the scans, interpreting the results and counseling patients very time consuming (usually 20 to 30 minutes) for which there is inadequate reimbursement already, not to mention the ability financially to pay for the DEXA machine.
You should be aware that DEXA was recently added by you as a preventative service in hopes of increasing utilization. Cutting reimbursement will only diminish the impact of your own Healthy People2010 Initiative.
It should also be noted that the assumptions used to recalculate the MPFS are inaccurate.
- The new technology should not be a trial and error policy.
- Majority of systems sold are the fan beam not pencil beam.
- Equipment is NOT used 50% 0f the time. In my case only about 10% of the time and I do all the scans myself.

Please reconsider this matter as soon as possible.

Allan Clemenger, M.D.

**Provisions of the Proposed Rule**

Provisions of the Proposed Rule

42101 N 41st Drive, #124
Anthem, AZ 85086
September 21, 2006

Allan K. Clemenger, M.D., L.L.C.
Attention Medicare:
RE: Document #1321-P ; Coverage of Bone Mass Measurement (BMM) Tests
As a Gynecologist who has been in clinical practice for over 40 years I see many women in their post-menopausal years. All these patients are at risk for Osteoporosis with its attendant risks of spine and hip fracture which are at the least disabling and at most lethal. Prevention of this condition is now quite possible medically if the individual is followed with serial bone mineral density scans. In view of this I feel no changes should be considered as to reimbursement for Bone Mineral Dexatometry. Should the reimbursements be cut as proposed it would be very difficult for me to continue to spend the time involved performing the scans, interpreting the results and counseling patients very time consuming (usually 20 to 30 minutes) for which there is inadequate reimbursement already, not to mention the ability financially to pay for the DEXA machine.
You should be aware that DEXA was recently added by you as a preventative service in hopes of increasing utilization. Cutting reimbursement will only diminish the impact of your own Healthy People2010 Initiative.
It should also be noted that the assumptions used to recalculate the MPFS are inaccurate.
- The new technology should not be a trial and error policy.
- Majority of systems sold are the fan beam not pencil beam.
- Equipment is NOT used 50% 0f the time. In my case only about 10% of the time and I do all the scans myself.

Please reconsider this matter as soon as possible.

Allan Clemenger, M.D.

**Submitter :** Dr. Gregory Mohr **Date:** 09/21/2006

**Organization :** Dr. Gregory Mohr

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

The vicious cycle of rapid growth in utilization and spending in the radiology arena is due to two major factors: self-referral to self-owned imaging centers (unfortunately, cardiologists seem to be the biggest offenders followed by orthopedic surgeons)and fear of lawsuits prompting the unnecessary ordering of imaging studies. Please call at 530-582-3426, if you would like to discuss further.

**Submitter :** Dr. Douglas Arthur **Date:** 09/21/2006

**Organization :** VCU Medical Center

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1321-P-254-Attach-1.DOC

Attach #
254

September 20, 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 23, 2006. This letter is written to share my concern regarding the proposed reduction in professional fees for radiation/oncology brachytherapy services.

The proposed reduction will have a detrimental impact on my ability to offer the most appropriate treatment options for my Medicare patients. Brachytherapy is a crucial treatment option for my breast cancer patients in that it allows the radiation process to move very quickly so that other treatments (chemotherapy) can be started as well. With that said, the preparation and effort to properly create a treatment plan is quite time consuming. In addition, I must reconfirm correct catheter placement before each fraction is given. The 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.

As a practitioner focusing on breast cancer treatment, I urge CMS to reconsider the proposed Work RVU reduction for brachytherapy, leaving brachytherapy 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,

*Douglas Arthur, MD*

Douglas W. Arthur, MD
Associate Professor, Department of Radiation Oncology
Virginia Commonwealth University
Richmond, VA

cc. Carolyn Mullen, Deputy Director, Division of Practitioner Services
Prabhakar Tripuraneni, M.D., Chair, American Society of Therapeutic Radiation and Oncology
James Rubenstein, MD, Chairman, American College of Radiation Oncology
W. Robert Lee, MD, President, American Brachytherapy Society

**Submitter :** Dr. John Jones

**Date:** 09/21/2006

**Organization :** Virginia Breast Care

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1321-P-255-Attach-1.DOC

CMS-1321-P-255-Attach-2.DOC

Attach #
255

September 20, 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 23, 2006. This letter is written to share my concern regarding the proposed reduction in professional fees for radiation/oncology brachytherapy services.

The proposed reduction will have a detrimental impact on my ability to offer the most appropriate treatment options for my Medicare patients. The preparation and effort to properly create a brachytherapy treatment plan is quite time consuming. In addition, I must reconfirm correct catheter placement before each fraction is given. The 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.

As a practitioner focusing on breast cancer treatment, I urge CMS to reconsider the proposed Work RVU reduction for brachytherapy. Please do not reduce payment rates for brachytherapy codes. I appreciate your careful consideration and review in this important matter and strongly urge CMS to reconsider the significant impact the proposal outlines.

Sincerely,

*John Jones, MD*

John Jones, MD
Virginia Breast Care
Charlottesville, VA

cc. Carolyn Mullen, Deputy Director, Division of Practitioner Services
Prabhakar Tripuraneni, M.D., Chair, American Society of Therapeutic Radiation and Oncology
James Rubenstein, MD, Chairman, American College of Radiation Oncology
W. Robert Lee, MD, President, American Brachytherapy Society

**Submitter :** **Dr. Sylvia Hendrix** **Date: 09/21/2006**

**Organization :** **Martha Jefferson Hospital**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1321-P-256-Attach-1.DOC

Attach # 256

September 20, 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 23, 2006. This letter is written to share my concern regarding the proposed reduction in professional fees for radiation/oncology brachytherapy services.

The proposed reduction will have a detrimental impact on my ability to offer the most appropriate treatment options for my Medicare patients. The preparation and effort to properly create a brachytherapy treatment plan is quite time consuming. In addition, I must reconfirm correct catheter placement before each fraction is given. The 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.

As a practitioner focusing on breast cancer treatment, I urge CMS to reconsider the proposed Work RVU reduction for brachytherapy. Please do not reduce payment rates for brachytherapy codes. I appreciate your careful consideration and review in this important matter and strongly urge CMS to reconsider the significant impact the proposal outlines.

Sincerely,

*Sylvia Hendrix, MD*

Sylvia Hendrix, MD
Central Virginia Radiation
Charlottesville, VA

cc. Carolyn Mullen, Deputy Director, Division of Practitioner Services
Prabhakar Tripuraneni, M.D., Chair, American Society of Therapeutic Radiation and Oncology
James Rubenstein, MD, Chairman, American College of Radiation Oncology
W. Robert Lee, MD, President, American Brachytherapy Society

**Submitter :** **Dr. Andrew Berkow** **Date: 09/21/2006**

**Organization :** **Radiology Group PCSC**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1321-P-257-Attach-1.DOC

HHS-CMS-1321-P-257

Radiology Group p.c., s.c.

1970 E. 53rd Street | Davenport, Iowa 52807 | **563.359.3931** | fax 563.355.1159 | **www.rgimaging.com**

9/21/2006

CMS-1321-P
REASSIGNMENT AND PHYSICIAN SELF-REFERRAL

---

**Issue #1: Whether diagnostic tests in the DHS category of radiology and other imaging services should be excepted from any of these provisions.**

Discussion: It is imperative that Radiology services should be INCLUDED under these provisions. As the Executive Director of a medical group providing interpretations, and as one who communicates regularly with other practices providing interpretations, I support this proposal and believe it must apply to radiology services in order to stem rampant abuse occurring under reassignment. The current in-office ancillary exception to self-referral results in tremendous over-utilization at great expense to all federal payment programs. What is often not well understood is the magnitude of abuse occurring under the guise of reassignment. Reassignment, under the current rules, allows self-referring groups to profit from both the TC and PC by paying the interpreting physician less than what the billing entity collects for that interpretation. Any discounts and savings should be realized by the Medicare program, not placed in the self-referring physicians' pockets.

---

**Issue #2: Should the anti-markup provision apply to the reassignment of the PC of diagnostic tests performed under contractual arrangement.**

Discussion: In order to stem some of the abuse seen in self-referral, the anti-markup provisions should apply. See discussion under Issue #1.

---

**Issue #3: How to determine the correct amount that should be billed to the Medicare program**

Discussion: Having experience in this area, as well as speaking with others who provide interpretive services, there are really only variations of 3 methodologies used to pay for interpretations under reassignment: 1) A flat fee per study; 2) a percentage of collections; or, 3) a discount from billed charges. In my experience, the vast majority of arrangements (90+% ?) fall into some variation of methods #1 or #2. The problem begins in that these claims are almost always submitted as a global charge, not separated on the claim as TC and PC. The first step would be to mandate separate billing for the PC and TC. However, you should be careful to write the rules in such a way that they apply ONLY to self-referring groups and IDTFs who contract with physicians outside their group for interpretation services under reassignment; the rules should not apply to physicians and medical groups that provide both the TC and PC components within the group, i.e., radiology practices. Keep in mind that in virtually all radiology groups, every physician "reassigns" their benefits to the group.

At the end of the day, the rule should mandate that 100% of all receipts collected for reassignment interpretations should be paid to the physician providing the interpretation, with no portion being kept by the entity providing the TC. The easiest way would be to require that the actual amount charged by the interpreting physician should be reflected on the claim. If the

"charge" is greater than the payment received, the rules should mandate that the entire amount received by the entity for the interpretation be paid to the physician providing the interpretation in these settings. If the interpreting physician is paid a flat fee, this flat fee should be entered on the billing entity's initial claim form, not some inflated fee. The rules should prohibit paying the physician under reassignment a percentage of collections as enforcement of any anti-markup provisions will prove to be impossible. There should be no reductions in the fees paid to the interpreting physician for the cost of collections since the entity is already experiencing those costs when they bill for the TC.

---

**Issue #4: The test must be ordered by a physician that is financially independent of the person or entity performing the test and also of the physician or medical group performing the interpretation; the physician or medical group performing the interpretation does not see the patient; the physician or medical group performing the interpretation does not see the patient; and, the physician or medical group billing for the interpretation must have performed the TC of the test.**

Discussion: I support all proposals in Issue #4. This set of rules, in and of itself, is the most important of all proposals, and will go a long way to stemming reassignment abuse. However, I believe it is in Medicare's interest to enact all proposed provisions.

Andrew E. Berkow, MD

Radiology Group PCSC

1970 E 53rd St.

Davenport, Iowa 52807

aebmd@aol.com

563-359-3931

**Submitter :** Dr. Chester Wilson

**Date:** 09/22/2006

**Organization :** Dr. Chester Wilson

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1321-P-258-Attach-1.DOC

Attach #
258

September 8, 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:

I appreciate the opportunity to express my views on the Centers for Medicare and Medicaid Services' proposed rule, published in the Federal Register on August 23, 2006. This letter is written to share my concern regarding the proposed reduction in professional fees for radiation/oncology brachytherapy services.

The proposed reductions for the RVUs namely the Work RVUs will not allow me to offer appropriate treatment options for my Medicare patients. Brachytherapy is an important therapy offered for breast cancer patients because it allows the radiation to be given in 5-7 days, which allows the process to move very quickly so that other treatments (chemotherapy) can be started as well. The Work component of the RVUs that you are proposing to reduce by at least 23% comprises the Physician's time to perform a service, technical skills and physical and mental effort involved in treating the patients. The preparation and effort to properly create a treatment plan is very time consuming. The 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. Choice, quality and availability is key for the beneficiary.

I strongly recommend that CMS reconsiders the proposed Work RVU reduction for brachytherapy. Please maintain the brachytherapy codes as is, and, if needed, make a reduction to the conversion factor. I appreciate your time and consideration in the review of this important issue and strongly advise CMS to reconsider the significant impact the proposal outlines. Thank you for the opportunity to express my opinion

Sincerely,

Chester Wilson, MD
Radiation Oncologist
Providence St. Joseph Medical Center
501 South Buena Vista St.
Burbank, CA 91505

cc: Senator Barbara Boxer, CA (D)
Senator Diane Feinstein, CA (D)
Congressman Henry Waxman, CA (D)

cc: Carolyn Mullen, Deputy Director,
Division of Practitioner Services

cc: American Society of Therapeutic Radiation and Oncology
Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation and Oncology

cc: American Brachytherapy Society
W. Robert Lee, MD, President, American Brachytherapy Society

**Submitter :** **Dr. Rajesh Khanijou** **Date: 09/22/2006**

**Organization :** **Dr. Rajesh Khanijou**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1321-P-259-Attach-1.DOC

Attach #
259

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,

I want to thank you for giving Physicians an opportunity to respond to the Center for Medicare and Medicaid Services' proposed rule, which was published in the Federal Register on August 22, 2006. I am very concerned with the proposed reduction of the RVUs of greater than 10 units when CPT code 19296 is performed in the office over the next few years as well as the proposed reduction of the conversion factor by 5.1%.

If the RVUs are reduced for the office setting, then the beneficiary may have to have services scheduled at the hospital. This can lead to more expenses and difficulty in scheduling and this is an important issue as it is important to start radiation therapy as soon as possible. I strongly believe the RVUs should be maintained as is or be minimally reduced. I will not be able to treat Medicare patients who desire Breast Brachytherapy in my office if the current proposal is adopted.

My solution is to review this information further and keep the current RVU values the same for now. I don't think you can reduce both the RVUs and the conversion factor. I recommend if anything is done, then please reduce the conversion factor.

Thank you again for giving me the opportunity to comment on this extremely important issue.

Sincerely,

Rajesh Khanijou, M.D.
Surgeon
1201 W. La Veta #303
Orange, CA 92868

cc: Senator Barbara Boxer, CA (D)
Senator Diane Feinstein, CA (D)
Congressman Henry Waxman

cc: Carolyn Mullen, Deputy Director,
Division of Practitioner Services

**Submitter :** Dr. James Pelton

**Date:** 09/22/2006

**Organization :** Dr. James Pelton

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1321-P-260-Attach-1.DOC

Attach #
260

September 8, 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:

I appreciate the forum to provide comment on the Centers for Medicare and Medicaid Services' proposed rule, published in the Federal Register on August 23, 2006. This letter is written to share my concern regarding the proposed reduction in professional fees for radiation/oncology brachytherapy services.

The proposed reductions will have a negative impact on my ability to offer the most appropriate treatment options for my Medicare patients. Brachytherapy is an important therapy offered for breast cancer patients because it allows the radiation process to move very quickly so that other treatments (chemotherapy) can be started as well. The Work component of the RVUs that you are proposing to reduce comprises the Physician's time to perform a service, technical skills and physical and mental effort involved in treating the patients. The preparation and effort to properly create a treatment plan is very time consuming. The 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. Choice, quality and availability is key for the beneficiary.

As a Physician focusing on breast cancer treatment, I strongly recommend that CMS reconsiders the proposed Work RVU reduction for brachytherapy. Please leave brachytherapy codes as is, and, if needed, make a reduction to the conversion factor. I appreciate your careful consideration and review in this important issue and strongly advise CMS to reconsider the significant impact the proposal outlines.

Sincerely,

James Pelton, M.D.
Radiation Oncologist
Overlake Hospital Cancer Center
1135 116th Avenue NE, Suite 160
Bellevue, WA 98004

cc: Senator Maria Cantwell WA (D)
Senator Patty Murray WA (D)

cc: Carolyn Mullen, Deputy Director,
Division of Practitioner Services

cc: American Society of Therapeutic Radiation and Oncology
Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation and Oncology

**Submitter :** Dr. Oscar Streeter **Date:** 09/22/2006

**Organization :** Dr. Oscar Streeter

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1321-P-261-Attach-1.DOC

Attach #
261

September 8, 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:

I appreciate the opportunity to provide comment on the Centers for Medicare and Medicaid Services' proposed rule, published in the Federal Register on August 23, 2006. This letter is written to share my concern regarding the proposed reduction in professional fees for radiation/oncology brachytherapy services.

The proposed reduction will have a detrimental impact on my ability to offer the most appropriate treatment options for my Medicare patients. Brachytherapy is an important treatment option for my breast cancer patients in that it allows the radiation process to move very quickly so that other treatments (chemotherapy) can be started as well. The preparation and effort to properly create a treatment plan is quite time consuming. In addition, I must reconfirm correct catheter placement before each fraction is given. The 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.

As a practitioner focusing on breast cancer treatment, I recommend CMS to reconsider the proposed Work RVU reduction for brachytherapy. Please leave brachytherapy codes as is, and, if needed, make a reduction to the conversion factor. I appreciate your careful consideration and review in this important matter and strongly urge CMS to reconsider the significant impact the proposal outlines.

Sincerely,

Oscar Streeter, MD
Radiation Oncologist
Norris Comprehensive Cancer Center
1441 Eastlake Ave
LA, CA 90033

cc: Senator Barbara Boxer, CA (D)
Senator Diane Feinstein, CA (D)
Congresswoman Hilda Solis CA (D)

cc: Carolyn Mullen, Deputy Director,
Division of Practitioner Services

**Submitter :** **Dr. Loan Tran** **Date: 09/22/2006**

**Organization :** **Dr. Loan Tran**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1321-P-262-Attach-1.DOC

Attach 11
262

September 16, 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 to express my opinion on the Centers for Medicare and Medicaid Services' proposed rule, published in the Federal Register on August 23, 2006. This letter is written to share my concern regarding the proposed reduction in professional fees for radiation/oncology brachytherapy services.

These reductions that have been proposed will have a detrimental impact on my ability to offer the most appropriate treatment options for my Medicare patients. Brachytherapy is an important therapy option for my Patients with breast cancer and gynecological cancer. It takes significant preparation and effort to properly create a treatment plan and it is quite time consuming. I must reconfirm correct catheter placement before each fraction is given and be concerned with the iatrogenic risk to the patient. The proposed reduction to all brachytherapy codes, especially CPT 77781 by 23%, would not even adequately cover the time and involvement required to prepare a patient for brachytherapy. By approving this reduction you will be limiting Medicare patient's access and choice for breast cancer therapy.

My recommendation is for CMS to reconsider the proposed Work RVU reduction for brachytherapy and maintain the current brachytherapy codes and, if needed, make a reduction to the conversion factor. Thank you again for the opportunity to express my recommendations.

Sincerely,

Loan Tran, M.D.
Radiation Oncologist
Good Samaritan Hospital
15400 National Ave., #100
Los Gatos, CA 95032

cc: Senator Barbara Boxer, CA (D)

Senator Diane Feinstein, CA (D)
Congressman Pete Stark, CA (D)

cc: Carolyn Mullen, Deputy Director,
Division of Practitioner Services

cc: American Society of Therapeutic Radiation and Oncology
Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation and Oncology

**Submitter :** Dr. Alice Police
**Organization :** Dr. Alice Police
**Category :** Physician

**Date:** 09/22/2006

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1321-P-263-Attach-1.DOC

Attach #
263

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,

I appreciate the occasion to relay my thoughts on the Center for Medicare and Medicaid Services' proposed rule, which was published in the Federal Register on August 22, 2006. I have some concerns regarding the proposed reduction of the RVUs of greater than 10 units when CPT code 19296 is performed in the office over the next few years as well as the proposed reduction of the conversion factor by 5.1%.

The reduction of the RVUs will make it difficult for me to treat Medicare beneficiaries in the office who present with Stage I or II breast cancer and would like to undergo Breast Conserving Surgery with follow up of partial breast irradiation. My practice expenses would exceed the reimbursement proposed by CMS with the reduction of RVUs. Patients prefer to have this procedure done in the office environment and I would like to be able to provide access and availability for Medicare patients. It is very important to maintain the current RVUs for this procedure as it will enable me to continue to treat Medicare patients in my office. By reducing the RVUs, CMS is limiting access to partial breast irradiation therapy.

My recommendation is that CMS review this matter again and keep the current RVUs for this procedure or have a reduction that is significantly less than the proposed rate. It may be more appropriate to have a small reduction in the conversion factor if you choose to make some adjustment.

I appreciate your careful review of this matter and strongly urge CMS to reconsider the significant impact the proposal may have for your Medicare beneficiaries. Thank you for your time.

Sincerely,

Alice Police, M.D.
Surgeon
351 Hospital Road
Newport Beach, CA 92663

cc: Senator Barbara Boxer, CA (D)
Senator Diane Feinstein, CA (D)
Congressman Henry Waxman

cc: Carolyn Mullen, Deputy Director,
Division of Practitioner Services

cc: American College of Surgeons
Mark A. Malangoni, MD, Chair, American College of Surgeons