Submitter : Dr. James Grannell **Date:** 08/03/2006

Organization : Niles Orthopedics P.C.

Category : Physician

Issue Areas/Comments

Discussion of Comments-
Orthopedic Surgery

Discussion of Comments- Orthopedic Surgery

This type of reduction will accomplish your purpose of decreasing expenditures because it will not be worth the effort to even so the tests...therefore not benefit to your constituents, no benefit to our patients and no decrease longterm expenses in the treatment of fracture associated with osteoporosis. You want us to help our patients but this another example of failing to fund or reimburse (and these current levels of reimbursement are modest at best) a very reasonable test for many female patients. You want to raise the bar for prevention of a treatable disease and then try to get the medical community to EAT the expenses. Shameful!

Submitter : Dr. Leslie Spry **Date:** 08/03/2006

Organization : Lincoln Nephrology

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

As a practicing nephrologist, I am frustrated by the poor compensation that I get for complex patient issues. I am frustrated by the lack of attention paid to patient care that does not involve face to face patient encounters. For instance, transplant patients frequently have lab done and assessed by me on a weekly basis, but I am only paid for the face to face time that I spend with the patient. In many of these patients, I deal with diabetes, hypertension, immunosuppression, vaccination status, bone disease, lipid management, and psychosocial issues. I also have to deal with Medicare Part D inconsistencies that totally perplex the patient. Pharmacies and I frequently have to be advocates for these fragile patients, but yet I only get paid for face to face encounters. For highly complex patients, this needs to be addressed. I am frequently paid better for dialysis patients, who are also highly complex, but I am paid the Monthly Capitated Payment (MCP), which goes away after transplantation. I transplant as many patients as I can, but this is a financial dis-incentive to do so. Some compensation for non-face-to-face medical decision making needs to be made for highly complex patients.

Submitter : Dr. Gonzalo Castillo **Date:** 08/04/2006

Organization : Dr. Gonzalo Castillo

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I strongly protest the CMS-proposed changes to the Physician Fee Schedule including substantial cuts to anesthesiology. As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses. CMS should gather new overhead expense data to replace the decade-old data currently being used. ASA, AMA, and many other specialties are committed to financially support a comprehensive multispecialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. CMS must address the issue of anesthesia work undervaluation or our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine.

Submitter : Dr. Kevin Kirtley **Date:** 08/04/2006

Organization : Northside Anesthesia Services

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

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

Submitter : **Date: 08/04/2006**

Organization :

Category : **Other Technician**

Issue Areas/Comments

Other Issues

Other Issues

Osteoporosis -DXA decrease in payments, these cuts will greatly effect the availablity of these services to patients. With the current availablity of medications to prevent the progression of this disease it would be a great loss to be unable to make early diagnosis with the use of DXA scans. Please reconsider these cuts scheduled for 2010, so providers can continue to offer these services.

Submitter : Julie Stubby **Date:** 08/04/2006

Organization : Osteoporosis Research Center

Category : Nurse

Issue Areas/Comments

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

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

I work as a research nurse at the Osteoporosis Research Center in Omaha, NE with Dr. Robert R. Recker and Dr. Robert P. Heaney. It is vital to provide coverage to patients to be screened for bone loss and also as follow-up to treatment. Detection, prevention and treatment of bone loss decreases costs related to fractures, especially hip fractures which have a high cost and mortality rate. If coverage for DXA scans is decreased, people will be less likely to have a scan, thus putting their bone health at risk and potentially increasing costs for medical care due to broken bones. I encourage you to reconsider decreasing reimbursement costs for DXa's.

Submitter : **Dr. Kevin Stuart** **Date: 08/04/2006**

Organization : **Dr. Kevin Stuart**

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 Gilroy, CA, and have been a Medicare participating provider since 1991. 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 4.7% 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,

Kevin D. Stuart, MD

9460 No.Name Uno, Ste 130

Gilroy, CA 95020

408 847-1311

Submitter : **Dr. Janahar Palaniappan** **Date: 08/04/2006**

Organization : **Dr. Janahar Palaniappan**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Is is my pleasure to write to you today on behalf of our cardiology practice. It has come to my attention that recently CMS has propsed reductions in physician fee schedule for the utilization of Bio-Z/ICG equipment.

After reviewing the proposed changes, I felt it necessary to voice my displeasure toward this change and I feel that at this time, this change is not acceptable. The Bio-Z/ICG is an intricate part of our cardiology practice and has been used consitently in conjunction with other evidence based methodology to help provide optimal patient care for the individuals that I am privileged to serve.

As with most industry overhead and technician costs continue to rise and the new method used to calculate reimbursement for this equipment will significantly decrease our compensation. This will also significantly impede our ability to upgrade our equipment and keep our healthcare costs at an acceptable level to our patients and health insurance providers.

Your attention to this matter is greatly appreciated.

Submitter : Dr. Donald Shears **Date:** 08/04/2006

Organization : Dr. Donald Shears

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

It is clear that any reduction in the physician fee schedule/conversion factor will have significant impact on the Professional services provided by Doctors across the country. The proposed cuts in the conversion factor by CMS using the "sustainable growth formula" is extremely flawed. The reduction of specific CPT codes for thoracis electrical bioimpedence/impedence cardiography and others will cause significant loss of revenues making it very difficult to sustain this service to our patients. This methodology is also flawed and should be changed/delayed. We implore CMS to reconsider these reductions, thereby allowing us to bring quality care to all of our patients.

Submitter : Dr. Kirk Crouser **Date:** 08/04/2006

Organization : Dr. Kirk Crouser

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I am not in support of the proposed changes to CPT code 93701 for impedence cardiogram. With my high equipment costs of over $30,000 and high testing cost, this reduction is not supportive of my medical practice cost and must be modified.

Submitter : Dr. Jan Bruder **Date:** 08/04/2006

Organization : UTHSCSA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I have recently heard that the Centers for Medicare & Medicaid Services (CMS) recently proposed regulations that will dramatically reduce reimbursement for the performance of DXA (CPT code 76075) from the current ~$140 to ~$40 by 2010 and VFA (CPT code 76077) from the current ~$40 to ~$25. These cuts would be in addition to the already-enacted imaging cuts in the Deficit Reduction Act of 2005. It is highly likely that this regulatory change in the Medicare Physician Fee Schedule will have profound effects on access to high-quality bone density testing and thus the diagnosis and treatment of patients with osteoporosis.

I addition as BMDs are repeated over time to monitor response to therapy or the resolution of secondary causes for osteoporosis, the comparison of the serial measurements take up more time. More expertise is also needed for proper interpertation.

Submitter : **Bruce Slater** **Date: 08/04/2006**

Organization : **University of Wisconsin**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

Dear CMS,

This is a letter of support for finalizing the recommended work RVU increases for Evaluation and Management (E&M) services.

I am a primary care physician (PCP) who frequently counsels patients about expensive surgical procedures they are contemplating. A careful prolonged discussion with the patient about their values and their expected outcomes of surgery with a non-surgeon is sometimes necessary for the patient to come to the best decision for their care. Primary care is mostly an intellectual service rather than a procedural one. RVUs were designed in favor of procedures and PCP's reimbursements have slipped further in relative value over the years compared with proceduralists. In this situation, CMS is counting on PCPs spending their undervalued time to save CMS from spending hundreds of times more money so that the patient gets the best care.

The doctrine of societal fairness seems to be broken by this situation.

When rational medical students see PCPs burning out and complaining about CMS and other insurance biases against intellectual work, they rationally chose specialties that society rewards. This has had the effect over the last 20 years of my experience of making the primary care access crisis worse.

Making E&M services more fairly compensated relative to procedures will help mitigate a possible collapse of primary care. If the imbalance does not get worse, but fails to improve, the trend in declining student interest in primary care will continue to drive patients to specialists to get care for primary care problems.

For example, I can take care of musculoskeletal low back pain significantly more efficiently than an orthopedic surgeon while still detecting patients with surgical lesions and referring them. If more low back pain goes to orthopedic surgeons, more resource will be utilized and the next round of budget neutral adjustments will punish the victims - PCPs. Ultimately the patients undergoing additional X-ray exposure and surgery will be the victims.

Patients advancing in age need PCPs and geriatricians who can take the time to keep the patients out of the hospital. PCPs rushing to keep their schedules moving to avoid financial collapse will be more likely to miss opportunities for helping this growing segment of our patients.

I urge CMS to finalized the recommended work RVU increases for E&M service and reject any efforts to lower E&M reimbursements which would favor proceduralists and continue as an affront to fairness.

Thank you for this opportunity to comment on this issue.

Bruce Slater, MD, MPH
University of Wisconsin, Madison
b.slater@hosp.wisc.edu

Submitter : Ms. Karen Remior **Date:** 08/04/2006

Organization : Orthopedics International ITD PS

Category : Individual

Issue Areas/Comments

Discussion of Comments-
Orthopedic Surgery

Discussion of Comments- Orthopedic Surgery

Once again I am agahst as Medicare prepares to lower reimbursements on CPT codes 27130,27447 and 27236. With the cost of doing business increasing daily how can you expect orthopedic surgeons to keep the doors open when their reimbursements are continuously lowered? This has been an ongoing practice for at least a decade. The Medicare patients, meaning senior persons are the ones that will pay for this nonsense. With the cost of liability insurance, not to mention the cost of health insurance for employees going up annually, the proposal to cut reimbursements for total knees,total hips and open repair of a femoral neck fracture is absurd. The time is coming when physicians will no longer be able to accept Medicare patients. That will affect a whole generation of us that are rapidly reaching Medicare age. The fact that we have spent most of our lives contributing to the Medicare tax seems to be of little concern for the rule makers. Total hip,total knee replacements and open treatment of a femoral fracture are not surgeries that are done on young people. What are you thinking? It is not people that have private insurance at their disposal that fracture hips. Simply stated it is the elderly. Medicare seems to be setting the precedent in this time which simply allows the private insurers to pay less and less each year. Maybe providers need to make private contracts with their patients in order to survive. I have worked in the medical field since 1982.

Submitter : Mr. Dorian GRunig **Date:** 08/05/2006

Organization : Bear Lake Memorial

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

ACTION FOR CONGRESS: CMS Administrator Dr. Mark McClellan. As an anesthesia provider I urge you to stop the Medicare anesthesia cuts. Such unprecedented, unwarranted, and unjustified cuts would have wide-ranging effects on hospitals and patients access to healthcare. Further, these cuts would take effect in addition to Sustainable Growth Rate (SGR) formula cuts of 4.7% expected January 1, 2007, unless Congress acts.
? Sudden anesthesia cuts unprecedented. The last two CMS 5-year review Part B payment formula changes, in 2002 and 1997, adjusted anesthesia payment work values less than one percent each. CMS now proposes to cut anesthesia payment work values by 10%.
? 2007 anesthesia payments regress to 1991 rates. In 1991, an average Medicare anesthesia service2 paid $186.00. If this cut and the SGR cut go through, Medicare in 2007 will pay $188.16 for an average anesthesia service.
? Medicare already undervalues anesthesia relative to market rates, compared with its reimbursement for other services. While Medicare pays about 80% of private market rates for most Part B services, Medicare pays only 37% of market rates for anesthesia services.
? Other factors, not anesthesia, causing massive cuts. Massive cuts are caused by other factors requiring increased scrutiny. CMS decision to increase Medicare evaluation and management (E/M) codes for only certain services by nearly 40%, increased Part B payments by $4 billion and forced Medicare to slash services such as anesthesia by 10%.
? Patient impact absent from CMS equations. Cutting anesthesia by 10% would certainly have effects on other aspects of the healthcare system critical to Medicare beneficiaries such as access and out-of-pocket costs.

Thank you. Dorian Grunig CRNA

Submitter : **Dr. Paul Lanken** **Date: 08/05/2006**

Organization : **Dr. Paul Lanken**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I am an internist/pulmonologist/critical care medicine specialist at an academic hospital. I strongly support an increase in RVUs for E&M Services. Case complexity and time to assure appropriate followup and transition continue to increase. Increases in RVUs for E&M Services will help to compensate for the added effort to provide medical care as an outpatient or inpatient for many Medicare patients. I urge you to strongly oppose attempts to block the increase in RVUs for E&M Services, whose need will only increase in the future as the Medicare population continues to age and have increased severity and number of chronic health conditions and their complications.

Submitter : **Dr. James Jistel** **Date: 08/05/2006**

Organization : **Dr. James Jistel**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Dear Sirs:

I am an Anesthesiologist in Houston Texas and am writing to protest proposed cuts in Medicare reimbursement for Anesthesiologists. As the business manager for my group of 7 physicians and 9 CRNA's I can tell you that current Medicare reimbursement DOES NOT COVER THE COST OF PROVIDING THE CARE. The methodology used to calculate practice expense is using outdated figures and needs to look at real costs from actual practices. I will be happy to show you my actual costs and expenses.

The demands for buget neutrality force the bulk of us to supplement a few specialties whose costs are very high.

As it stands now many hospitals must pay a stipend just to keep an Anesthesia Department when they have a large Medicare population. As we all age this will certainly become more widespread.

Medicare patients are the oldest and sickest patients in a practice. They demand more time, skill and attention than any others. Yet they pay the least. If given a choice I would not treat Medicrae patients since they essentially cannot pay for their own care.

Please gather new realistic practice expense data!

James R. Jistel, M.D.

Submitter : Dr. Larry Kohse **Date:** 08/05/2006

Organization : none

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

In my humble opinion, Evaluation and Management services are highly underpaid and reimbursement for all procedures (X-rays, Dexa scans, invasive procedures, CT scans etc) are highly overpaid. The USA needs to get more in line with other first world countries which do not make multimillionaires out of procedure based physcians. The high reimbursement for procedure/CPT fees leads to tremendous abuse of the medical system in the USA. I strongly support lowering fees for CPT codes by 50 to 90% from current high levels.

Submitter : **Dr. Tanuja Mainkar** **Date: 08/05/2006**

Organization : **Anesthesia Associates ltd**

Category : **Physician**

Issue Areas/Comments

Other Issues

Other Issues

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

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

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

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

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

Submitter : **Dr. Bonnie Tesch** **Date: 08/05/2006**

Organization : **Advanced healthcare SC**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments-
Evaluation and Management
Services

Discussion of Comments- Evaluation and Management Services

I am writing to ask you to finalize the recommended changes in work RVUs for evaluation and management services. As a general internist, I care for an increasing number of older adults with multiple chronic medical illnesses. It is not uncommon for these patients to have from 4-5 active medical problems which require attention at each office visit. I find I am spending increasing time with patients like this with decreasing reimbursement for time and effort. I enjoy seeing these patients and know it is the sick not the well who require physicians, but I am concerned that without adjustemknt in RVUs, older sicker patients may lack access to internists in the future. Also, as a teacher of medical studemts, i have been seeing students observe the reimbursement compared with the effort and time in general internal medicine and choose other fields of medicine.
These changes in RVUs for E&M services will assure continued access to high quality primary care.

Bonnie Tesch FACP

Submitter : Dr. James Lessard **Date:** 08/06/2006

Organization : Valley Bone & Joint Clinic, pc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The planned decreased reimbursement for DXA scanning for osteoporosis will effectively eliminate my ability to offer this service to my patients. I currently care for somewhere around 500 patients with this disease and have seen a significant decrease in fractures; however, I just cannot afford to offer testing at a loss. I hope you will reconsider the planned decreased reimbursement.

Thank you for your attention.

James A. Lessard, MD
Rheumatology & Clinical Densitometry

Submitter : Mrs. Sue Cooper **Date:** 08/06/2006

Organization : Washington Radiology Associates

Category : Other Technician

Issue Areas/Comments

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

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

I am a Certified Densitometry Technologist (CDT) currently working at Washington Radiology Associates in Sterling Virginia. The approval of the Federal Regulation CMS-1512-PN released June 21, 2006 may lead to my employer eliminating Bone Densitometry services in our practice.
A provision in the Deficit Reduction Act of 2005 requires that the Medicare payment for the technical component (e.g., equipment, non-physician personnel, supplies, and overhead) of an imaging service be set at the Hospital Outpatient Department (HOPD) payment rate, if the HOPD rate is lower than the Physician Fee Service (PFS) payment rate. Imaging services include DXA, ultrasound, CT, and MRI, but not mammography. This provision is scheduled to become effective January 1, 2007. If Congress does not repeal the provision, it will undermine patient access to DXA and other imaging services by increasing co-pays, wait times and travel time for Medicare beneficiaries. This limitation on patient access will result in less timely diagnosis and delay the initiation of treatment.

In addition to the direct detrimental impact on patient health, the effect of the payment cuts on the delivery of imaging services in the physician s office will be significant. The provision could force physicians to discontinue providing DXA based on cost considerations. By linking payments for DXA and other imaging services to the HOPD rate, the reimbursement will not accurately reflect the actual costs of owning and operating imaging equipment. This will result in greatly reduced funds available for equipment maintenance and well-trained staff to support the equipment. For DXA, reimbursement for the bone densitometry tests necessary for the diagnosis of women at risk for osteoporosis (a recently enacted Medicare screening benefit) would be reduced by over 40%. Imaging services, which account for approximately 10% of overall Medicare spending, are slated to absorb more than one-third of the Medicare cuts in the Deficit Reduction Act.
Osteoporosis is a common disease affecting more than 25 million people in the US. Estimated yearly US health care costs were at least 17 billion dollars a year in 2003 with further yearly increases given the aging US population. There is an attendant significant increase in morbidity and mortality. HEDIS (Health Plan Employer Data and Information Set) 2006 Measures now include osteoporosis management in women and will look at the frequency with which women who fracture receive a bone mineral density test and an appropriate prescription. There are insufficient DXA machines in the HOPD setting to diagnose and monitor patients with this disease. Quality of care will suffer when the patient s treating physician is unable to continue to perform in office DXA imaging.
In most instances, patients pay higher co-pays for imaging services in the hospital out-patient department, as co-pays are 40% in the HOPD versus 20% outside of the HOPD. This new policy will be particularly burdensome for low-income patients and those living on fixed incomes.
On average, patients already wait ten days to two weeks for non-urgent imaging services provided in the hospital outpatient department. Reduced access to DXA and other imaging services in the physicians office and in free-standing imaging centers would increase these wait times resulting in less timely diagnosis and delays in treatment.
Since the payment cuts will make providing imaging services more expensive, Medicare patients in rural areas may be forced to drive long distances for imaging services due to a lack of providers.

Sincerely,
Sue M. Cooper RT(R)(CDT)

Submitter : Dr. Helen Noble **Date:** 08/06/2006

Organization : Internal Medicine Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a general internist in private practice for over 15 years, I have seen the work involved in caring for Medicare age patients increase drastically. Patient, family and societal expectations are greater. Options for treatment, with associated risks, are much higher in number, as are multiple, overlapping and sometimes conflicting guidelines. Balancing issues of quality-of-life and prudent geriatric, sometimes end-of-life, care with patient preferences and available treatments takes knowledge, experience and careful discussion. Primary care physicians trained to care for elderly patients in this manner are becoming fewer and stretched to the breaking point. Without them the system will fail. It is critical that E&M work in outpatient, inpatient and nursing home settings be recognized and compensated at a higher rate.

Submitter : Dr. ALice WIlliams **Date:** 08/06/2006

Organization : Dr. ALice WIlliams

Category : Physician

Issue Areas/Comments

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

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

I am writing to comment on proposed cuts in reimbursement for bone density studies. My multispecialty group practice does perform bone density studies for evaluation of patients with possible osteoporosis and for management of patients with osteoporosis. These studies are critical for evaluation and treatment so as to reduce fractures. There are proposed quality measures for osteoporosis, which include bone density studies.

I participate in reading bone density studies in our group. My colleagues and I have additional training to do this; all of us are certified by the International Society for Clinical Densitometry. It takes me an average of 10 minutes per study to prepare a report. This is on top of the time spent by our technicians who obtain historical information from the patient about prior fractures, risk factors (e.g. menopausal status, family history and certain medications) and treatment and then perform the bone density test. My technicians schedule patients every half hour.

This service cannot be provided for the $40 projected payment per test projected by 2010. Such a payment will result in providers discontinuing bone density tests. I conclude that some of the assumptions used for calculation the fee schedule must be inaccurate.

I hope you will reconsider the payment change in light of information such as the above.

Sincerely,

Alice A.S. Williams
Fallon Clinic

165 Mill Street
Leominster, MA 01453

Submitter : Dr. Brad Butler **Date:** 08/06/2006

Organization : Dr. Brad Butler

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

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

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? 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 : Mr. Steven Rabinowitz **Date:** 08/06/2006

Organization : Nurse Anesthetist

Category : Nurse Practitioner

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

I have been a nurse for over 26 years and have provided safe anesthesia as a nurse anesthetist for the last 12 years. I work 40 hour weeks plus on call evenings , nights and weekends and am entrusted with providing safe care to my patients, to maintain their blood pressure, heart rate, respirations, and temperature while surgeons are performing operations. The proposed regulation changes 71 FR 37170 6/29/2006 mandating a 7-8% cut in anesthesia reimbursement by 2007 and a 10% cut by 2010 are outrageous.The average reimbursement will fall and at 12 base units will be approximately $188.00 per case.
Does the government place a value of only $188.00 on the services I provide, namely keeping someone alive when they are under anesthesia at the same time holding me to such a high standard that any negligence can cost me millions of dollars and my livelihood. The patients are getting sicker and older and require more care in a shorter time frame. Reimbursement should rise for anesthesia or at the very least the agency should suspend its proposal of such outrageous cuts while an extensive review is done on the impacts of these proposed cuts. As margins shrink patients will suffer as they are pushed through the system while the providers try to make a living wage to take into account their investment in education, their long hours and the responsibility and accountablity required of them as healthcare professionals. Anesthesia providers are the angels that watch over you or your family as they sleep thru a lifesaving/improving surgery lets not short change them.

Submitter : Dr. Neville Sarkari **Date:** 08/06/2006

Organization : Choice Care Associates, PSC

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I am a physician in private practice. I believe the proposed reduction planned in the Work RVU and practice costs for DXA Scans (CPT 76075) will lead to decreased access for patients to comprehensive, quality bone health care.

High quality DXA reporting requires skilled interpretation of multiple results from the instrument. The CMS finding that physician work is "less intense and more mechanical" is inaccurate.

The practice expense technical component was figured using "pencil beam" technology which is now out of date. I am in solo practice and use a "fan beam" instrument which costs much more. The equipment costs for 76075 should remain at $85,000, the same as for the Vertebral Fracture Analysis code.

Furthermore, additional practice costs such as service contracts, upgrades, and quality control costs were omitted when calculating practice costs.

I strongly oppose any reduction in the reimbursement for DXA Code 76075. Such cuts are at odds with several Federal Initiatives to improve bone health. Physicians are trying to help meet the goals of these initiatives and such cuts will thwart access to this care.

Submitter : Dr. Ladislas Lazaro **Date:** 08/06/2006

Organization : Dr. Ladislas Lazaro

Category : Physician

Issue Areas/Comments

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

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

I am a Rheumatologist specializing in Osteoporosis, currently in solo practice in Lafayette, Louisiana. I am ISCD certified and for the past 12 years have been engaged not only in an active practice involving diagnosis and treatment of osteoporosiss, but also the formal education of physicians on a both a local and a national level in regard to the diagnosis and treatment of osteoporosis.

DXA is an essential tool in the management of the disease process of osteoporosis. Treating this asymptomatic, but devastating disease will be made even more difficult if the planned cuts of DXA reimbursment are enacted. These cuts are in direct conflict with multiple federal mandates including The Bone Mass Measurement Act, the U.S. Preventative Task Force recommendations and the Surgeon General's Report on Osteoporosis 2004.These Federal initiatives along with improved medications to treat osteoporosis and a greater clinical awareness of the disease process, of which DXA monitering in private offices across the USA contributes to greatly, have resulted in much improved bone health, and reduction in fractures of the many Americans at risk for fracture.

The presently calculated reduction in reimbursment is based on several flawed calculations made by CMS.

Calculations on the cost of the technical component were made based on outdated pencil beam technology, not fan beam technology, leading to the conclusion that operating expenses were much lower than they truely are. In fact the true expense of owning and operating DXA is twice the results of the present calculations.

Equipment utelization was also miscalculated, in this case greatly OVERESTIMATED! I have a veery busy practice and see about 25-30 patients per day and, yet only perform 2-3 DXAs per day. That is a utlization of only 12.5%, not nearly the 50% equipment utelization as stated in the present estimates by CMS. The present estimates were based on high volume imaging centers, not individual private practices.

Lastly, CMS greatly underestimates the degree of difficulty of adequately interpreting a DXA. Sure, the machine feeds out a set of numbers, but every DXA report I dictate includes reccomendations for medication treatment, nutritional aids, and physical exercise, all indiviually tailored for that specific patient based on information I collect prior to testing. Although the machine formulates the numerical calculations, the final and complete process of DXA interpretation done properly is very clinical and requires a great deal of education, experience, and judgment.

In summary, not only do the potential cuts on DXA reimbursment directly contradict multiple federal mandates relative to the diagnosis and treatment of osteoporosis, but present estimates of equuipment expense, operating utelization, and complexity of performing DXA interpretation utelized by CMS to calculate reimbursment greatly underestimate the true value of the procedure.

Clearly, any cuts in reimbursment to DXA will greatly limit patient access to this most valuable tool utelized in the agressive diagnosis and treatment of osteoporosis as mandated in the Surgon General's 2004 Report on Bone Health and will thus greatly compromise the quality of care we as physicians can offer our Medicare patients.

I urge you to take some time to reflect on these most earnest and genuine coments before simply proceeding in haste with this legislation.

Thank You
Ladislas Lazaro IV

Submitter : Dr. Timothy Connelly **Date:** 08/07/2006

Organization : New England Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties.
The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses.
CMS should gather new overhead expense data to replace the decade-old data currently being used.
ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.
CMS must address the issue of anesthesia work undervaluation or our nation s most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine.

Submitter : Dr. John Matlock **Date:** 08/07/2006

Organization : Dr. John Matlock

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

In the setting of preventive care, bone density screeningis one of the most cost effective methods. Also, with osteoporosis treatments nearing generic availability, cost of treatment will decline. However, the cost of performing bone density assessment is rising with increased cost of machines and their maintenence. Our group of 6 internists will stop performing assessment if these new reimbursement levels are implemented. We will have no choice as performing the test will actually be a money loser.

Submitter : Jeanne Allen **Date:** 08/07/2006

Organization : Jeanne Allen

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

As a social worker, approx 15% of my practice serves medicare/medicaid recipients. Over the past ten years, social workers have coped with fee reductions related to managed care. While others receive cost of living increases, we have had to work harder to maintain our incomes. We have been resourceful, reducing practice expenses while providing quality service. Our quality service results in lower malpractice insurance because we are committed to ethical practice. A decrease in fees to social workers will result in a decrease of services to recipients at this time. I will be forced to reduce the percentage of medicare/medicaid recipients in my practice. Please do not reduce the work values for social workers. Please withdraw this proposal until the funds are available to increase fees for all providers. Finally, do not approve a bottom up formula to calculate practice expense! We have worked so hard as a group to maintain our practice standards and support ourselves! Please do not punish us further and punish the wonderful people who rely on our professional expertise.

Submitter : Dr. Larry Petersen **Date:** 08/07/2006

Organization : Dr's Petersen

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

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.

I am pleased that CMS understands the importance of improving payment, both to recognize the substantial increase in costs and time that most family medicine practices are experiencing, and to help lessen the gap in payment between primary care and other specialties. Further, this payment increase is an important first step in addressing the looming shortfall in access to primary care services that is projected, as fewer physicians choose family medicine and other primary care specialties.

Submitter : Dr. Myrtle Hawkins **Date:** 08/07/2006

Organization : Dr's Petersen

Category : Physician

Issue Areas/Comments

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Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

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Submitter : Dr. Leslie Foote **Date:** 08/07/2006

Organization : Dr's Petersen

Category : Physician

Issue Areas/Comments

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Evaluation and Management
Services**

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Submitter : Caraline Blair **Date:** 08/07/2006

Organization : American Physicians, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

E&M codes have historically been undervalued and warrant a minimum of 10% increase in 2007, off-set by decreases in overpaid procedure/surgical codes. Continued poor reimbursement for E&M codes will cause detriment to the PCP services, resulting in increased hospital expenses.

Submitter : Mr. Paul Eden **Date:** 08/07/2006

Organization : American Physicians, Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I believe it is always better to incentivise by appropriate renumeration improved primary care. Increasing payment on E&M codes will help bring the best and brightest physicians to internal medicine amoung other specialties thus improving patient health because they will receive appropriate care more quickly.

Submitter : **Dr. Patricia Hale** **Date: 08/07/2006**

Organization : **Glens Falls Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1512-PN-1044-Attach-1.DOC

CMS-1512-PN-1044-Attach-2.DOC

Attach #1044

Glens Falls Hospital
Big-City Medicine. Hometown Care.

100 Park Street
Glens Falls, NY 12801
(518) 926-5919
www.glensfallshospital.org

August 7, 2006

Dear Sir or Madam:

I am writing this letter in regard to recent proposals to cut reimbursement rates for DXA, VFA and other imaging screening tools. These cuts will no doubtedly decrease the availability of high quality, precision screening tools for the diagnosis of crippling diseases such as osteoporosis.

In addition to being a board certified Internist with a special interest in women's health and osteoporosis for the past 10 years, I currently serve as the Medical Director for the New York State Osteoporosis Prevention & Education Program in Upstate New York and the Glens Falls Osteoporosis Center and Adirondack Regional Osteoporosis Coalition (AdROC).

Both of these organizations have made great advances in the rural upstate New York by educating people about the importance of getting high-quality DXA screening for the reduction, prevention and maintenance of osteoporosis. The cuts you are proposing will not only undermine the work we have already done but will put a great number of people at risk for developing osteoporosis.

With the work of organizations like mine and the recent call to action by the United States Surgeon General, proposals like yours, are sending mixed messages to our consumers about the health care delivery system.

When examining these reimbursement reductions, I urge you to keep in mind that the estimated national direct care expenditures (including hospitals, nursing homes, and outpatient services) for osteoporotic fractures are approximately $18 billion per year and costs are rising.

Please keep the current reimbursement rates as they now stand. You will be helping millions of Americans stay healthy.

Sincerely,

Patricia L Hale MD, PhD, FACP

Submitter : Ms. Melissa Lukose **Date:** 08/07/2006

Organization : medical student

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses. CMS should gather new overhead expense data to replace the decade-old data currently being used. ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. CMS must address the issue of anesthesia work undervaluation or our nation s most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine. As a medical student interested in pursuing anesthesiology as a career, this indirectly affects me greatly.

Submitter : LEE ANN BARSIC **Date:** 08/07/2006

Organization : LEE ANN BARSIC

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

WHY ARE WOMENS ISSUES AND TESTING THE FIRST TO TAKE REIMBURSEMENT CUTS? IT TOOK SEVERAL YEARS FOR INITIAL INSURANCE REIMBURSEMENT WHEN THE BONE DENSITY TEST FIRST CAME OUT. OSTEOPOROSIS IS A DEBILATING DISEASE AND WILL END UP COSTING INSURANCES EXCESSIVE AMOUNTS OF MONEY COMPARED TO THE COST OF THE ACTUAL BMD TEST. FINALLY THERE ARE PREVENTATIVE MEASURES FOR OSTOPOROSIS BUT THE DECREASE IN REIMBURSEMENT FOR THE BONE DENSITY WILL PUT EVERYTHING BACK AT SQUARE ONE. SINCERELY,LEE ANN BARSIC

Submitter : **Dr. David Dale** **Date: 08/07/2006**

Organization : **University of Washington Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the proposed increase in work relative value units (RVUs) for office & hospital visits & consultations that physicians services under the Medicare & Medicaid services programs.

I am an internist practicing at the University of Washington Medical Center in Seattle and my many other experiences and contacts. I know how important increasing the RVUs for evaluation management services is to preserving general and primary care medical services for the American public. The American College of Physicians has labeled the current status of primary care in our country as on the verge of collapse and in some places and for some population should already has collapse. I urge you to reject any comments that might reduce the proposed changes in RVUs for evaluation management services.

Sincerely

David C. Dale, MD
Professor of Medicine
University of Washington
Department of Medicine

Submitter : Mrs. C Cook-Stuart **Date:** 08/07/2006

Organization : Triton Healthcare

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

M/care is already demanding Physical therapists complete more paperwork than any other carrier, which, of course, adds to the expense of provideing care. The cost of employee PTs is going up. How are clinics to absorb all the cost increases with a proposed decrease in reimbursement? I'll tell you how...they will stop taking m/care patients. I'm seeing that already here in the south. then who will care for our elderly patients?

Submitter : **Mr. Larry Ohman** **Date: 08/07/2006**

Organization : **Institute of Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

As a physical therapist in private practice I am greatly concerned about the proposed changes in the physician fee schedule. Our practice serves a great number of Medicare patients who need PT and who have no other source of payment. Our margin for providing service for Medicare is already small and decreasing fees for PT will greatly affect our ability to provide care and even jeopardize our ability to remain a viable PT practice. We simply can not provide the level of service necessary with a reduction in fees. Please reconsider the reimbursement schedule so that we may provide the necessary services our patients deserve.

Respecfully submitted,
Larry Ohman PT, OCS

Submitter : **Date: 08/07/2006**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

Please see attached document for comments.

CMS-1512-PN-1050-Attach-1.DOC

Attachment #1050

BERKSTRESSER
& ASSOCIATES
REHABILITATION ADVISORS

11923 Meadowdale, Ste A
Stafford, Texas 77477
(281) 495-6331
berkassoc@swbell.net

August 7, 2006

Mark McClellan, M.D., PhD.
Administrator
Centers for Medicare and Medicaid Services

Dear Dr. McClellan,

I am a physical therapist who has practiced in the state of Texas for the last 30 years in a variety of settings and now provide management consulting services to providers around the country. One of the main areas of concern I address for physical therapists is dwindling reimbursement for services while practice expenses and living expenses continue to rise.

The purpose of this letter is to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for calculating practice expense RVU's under the Medicare physician fee schedule. I want to urge the CMS to insure that the proposed severe reduction in reimbursement for services provided by a physical therapist does not occur. At issue is the ability of physical therapists to continue to provide care to beneficiaries of the Medicare program that truly addresses the patients' needs. Further reimbursement cuts will limit the access to care as well as the outcomes of care for these most needy patients. It is my recommendation that CMS transition the changes over a period of time to allow for practice adjustments as necessary to insure the continued provision of services.

The "Sustainable Growth Rate" formula, if continued over the years, will result in a 37% reduction in fees to physical therapists by 2015. Any business would be hard pressed to continue operations with such income cuts, at a time when all other expenses continue to rise. I realize there is a planned increase in reimbursement for the Evaluation and Management codes, however physical therapists cannot bill the E&M codes. Therefore, with the planned cuts and no relief or increases in other areas in sight, 2007 would be a devastating year for the physical therapy community. I believe the value of physical therapy services to the long term quality of life for the Medicare beneficiary is not acknowledged under the planned scenario, and the results will be felt by many seniors in need of services, as well as by the providers of such services.

Thank you for your time and consideration of my comments on this important matter.

Sincerely,

Patti Berkstresser, P.T.

Submitter : Gerry Van Dyke **Date:** 08/07/2006

Organization : Gerry Van Dyke

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

Dear Dr. McClellan

I am writing to you in regards to the "five year review" proposed regulations that essentially reduce payments to physical therapists at least 6% in 2007. I do not understand the logic of cutting payments to the few physical therapists that remain Medicare providers. Access to quality physical therapy and medical care is already limited due to low reimbursement rates. Every year, more experienced health care professionals decide to leave Medicare than join (as providers). Even without cutting reimbursement rates, many health care professionals will opt out of Medicare in the coming months and years.

People can argue all day about the best way to "save" Medicare. Encouraging professionals to leave Medicare by continually reducing their reimbursement will not "save" Medicare. The government should be trying to find a way to recruit the best health care providers for Medicare. Maybe if Medicare was the only health insurance plan provided to current and retired government employees, more (some?) effort would be given to improving the quality of the program. The proposed RVU's revision is another step in the wrong direction.

Sincerely,

Gerry Van Dyke PT, SCS, ATC
(831) 688-1212
gerry@coastrehab.com

Submitter : Dr. Joseph Girgis **Date:** 08/07/2006

Organization : Dr. Joseph Girgis

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

Thoracis Electric Bioimpedence, CPT code 93701, has been an integral part of our practice for the past 3 years. I have reviewed the propsed changes to the RVUs for code 93701 for 2007 and find that they are abysmally lacking in their appropriateness.

Our practice expenses have increased to do this test, they have not decreased! Since we bought our first CarioDynamics BioZ unit 3 years ago the costs have been substantially higher for all of our next 3 units, the costs to have someone perform the test has risen and the overhead in the office has increased. I find it puzzling that you would consider reducing the RVUs for the practice expenses considering that ALL components of performing the procedure have risen in cost.

I do not know the amount that you believe a CardioDynamics BioZ Dx device costs, but our cost for a new unit was in excess of $35,000. You would be well served to consider no change to this procedure since in my opintion this device allows me to better control my heart failure patients and keep them out of the hospital - thereby saving your considerable dollars!

I would wholeheartedly support and increase in the practice expnese RVU to offset my increasing costs. As a worst case scenerio, I would expect it to remain the same as its current level.

Submitter : Dr. Rodney Iancovici **Date:** 08/07/2006

Organization : Dr. Rodney Iancovici

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

Regarding CPT 93701, I think Medicare lowering my reimbursement for this item is criminal. We try to do our best as Physicians. We get paid less and less. When does it end?

Submitter : **Dr. Kathleen Fearon** **Date: 08/07/2006**

Organization : **Dr. Kathleen Fearon**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I do not support the reduced RVU proposal for CPT 93701. With our eqipment cost of $40,000 and our disposable costs per month, I feel the reduced reimbursement is not justified not only because of cost, but the usefulness as a medical tool for treatment decision.

Submitter : Dr. Robert Schlamowitz **Date:** 08/07/2006

Organization : Dr. Robert Schlamowitz

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed reduction in RVU factors for CPT 93701 do not represent the real treatment environment currently passed for providing care to my patients. All of my practice expenses have risen over the past few years including malpractice premiums, bio-impedence disposables, technician expenses, general office costs including insurance, utilities and staff costs.

Submitter : Dr. Matthew Inman **Date:** 08/07/2006

Organization : Dr. Matthew Inman

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I do not believe in the proposed reduction in RVU's and reimbursement for CPT code 93701. With my work and practice costs, the reduction is not justified.

Submitter : Dr. Leif Christensen **Date:** 08/07/2006

Organization : Dr. Leif Christensen

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

In reference to the proposed RVU amount for CPT code 93701, I feel this is not acceptable to us as Physicians. The new methodology used to calculate the RVU amounts for practice expense for CPT 93701 results in a significant decrease in the reimbursable amount that is not compatible with increasing practice expenses for the procedure.

a. Thoracic bioimpedence equipment prices are increasing
b. Thoracic bioimpedence disposable prices are increasing
c. Technician costs are increasing
d. Overhead is increasing

Almost all of the thoracic impedence devices in use today are made by CarioDynamics. The equipment cost estimate of $28,625 that CMS has used in previous years as an input to the practice expense is not accurate, and must have been based on previous CardioDynamics models that have been discontinued or based inappropriately on used equipment pricing. The latest model is significanly more expenseive. I have had to pay $38,938 for my equipment.

I would greatly appreciate it if you would reconsider the proposal to decrease the RVU for the CPT code 93701.

Submitter : **Dr. Paul Block** **Date:** **08/07/2006**

Organization : **Dr. Paul Block**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Reducing the RVU for CPT 93701 is not advisable due to the increasing cost of technician costs and overhead to perform this test. Additionally, the high costs of the sensors necessary to run a test further devalues the allowable amounts.

Submitter : **Dr. Madras Padmanabhan** **Date: 08/07/2006**

Organization : **Dr. Madras Padmanabhan**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Reducing the RVU amount for CPT code 93701 to an amount that will cause a 10% reduction in the allowable amount is not commensurate with the costs to actually conduct a test. The preventive value of impedence cardiography to keep patients out of emergency room situations saves the health care industry thousands of dollars. Comparing a $48 allowable to a $5,000 emergency room visit seems like a small costs; however, a 10% decrease for running each ICG test will greatly affect my ability to utilize the ICG to its fullest.

Submitter : **Dr. Gary Pevnick** **Date: 08/07/2006**

Organization : **Physical Therapy Consultants, Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

Dear Sir,
By reducing payments for Part B providers by 10% for out patient physical therapy services in 2007, this would create a grave impact on all participating providers in rendering services to the Medicare constituent. It is difficult to manage a practice today with continuing increased cost associated with the provision of services. I hope you are understanding of this matter before asserting this reduction.
Thank you very much for your consideration.

Sincerely Yours,

Gary F. Pevnick, PT, DPT
314-653-0918 ext. 112

Submitter : **Elizabeth Hampton** **Date: 08/07/2006**

Organization : **Core Therapeutics Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

CMS is considering reducing physical therapy reimbursement for treatment of medicare clients. Reimbursement for Medicare is already below most of my insurance carriers. I take Medicare because sometimes the importance of 'mission' outweighs 'margin'. If CMS reduces their reimbursement for physical therapy, my small clinic, along with others, will stop taking Medicare clients. In our area in Washington state, we have few MD's that take Medicare, and people cannot find a primary care provider.
CMS should instead look at standardizing the reimbursement according to cost of living. Washington state gets reimbursed much less than Oregon, for example. Protect our elders and do NOT cut Medicare reimbursement for Outpatient physical therapy. We are the ones that spend the time with the clients, prevent falls, get them stronger and frequently communicate critical information to the doctor, who only could spend 5 minutes with them and may have not been told something critical about their health.

Submitter : Dr. William Diehl **Date:** 08/07/2006

Organization : Dr. William Diehl

Category : Physician

Issue Areas/Comments

Discussion of Comments- General, Colorectal and Vascular Surgery

Discussion of Comments- General, Colorectal and Vascular Surgery

Regarding CMS-1512-PN I would like to comment on what I hope multiple other colleagues must have brought to your attention. I understand that the changes made to the formula determing RVU's must be "Budget Neutra". However, our expenses are anything but "Budget Neutral", in particular when dealing with malpractice insurrance premiums. In the year 2002 my malpractice premiums were just under $20,000 Dollars a year. Next year they will be right around $90,000 a year.How can the US Government justify a payment formula based on historically discounted services,and a fee schedule that is several years old when the real costs of running a practice have grown in an exponential fashion? I continue to participate with the Medicare program because I feel it is a moral obligation to care for the elderly of this country. Nevertheless, I am enraged by a system that does not fairly compensate physicians and other components of the healthcare system fo the extraordinarily large amount of work and effort that goes into taking care of this segment of the population. The cost of running a practice will continue to escalate while the payment remains "Budjet Neutral". You explain to me how this is a fair system.

Submitter : **Mr. John Dennis** **Date: 08/07/2006**

Organization : **Physical Therapy at Dawn**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

Dear Sir or Madam,

I recently opened a small private practice in Albuquerque, NM. I currently am enrolled as a participating provider in the Medicare program, not because it is particularly lucritive, but because I choose to shoulder the diminished reimbursement in order to provide outstanding care to many of our local seniors who may otherwise not receive such care. Our budget can not sustain aggregate reimbursement cuts of 10% or even 5%. These cuts may render me unable to remain a provider for Medicare. Please thoughtfully reconsider this strategy for cost savings. I fear it will come at the expense of excellent care for our seniors.

Respectfully,
John P. Dennis, Jr., PT, OCS

Submitter : **Mr. Art Lubinski** **Date: 08/07/2006**

Organization : **Physiotherapy Associates**

Category : **Physical Therapist**

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

Re: Docket: CMS-1512-PN - Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Before my arguement challenging the results of CMS-1512-PN, consider these established points:

Consider budget neutrality as essential to a fiscally sound governing body, but not an algebra equation with value increases on one side leading to proportional and logical decreases elsewhere.

Relative Value Units are multifactoral assuming licensed competent healthcare professionals performing skilled, medically necessary intervention to the appropriate clientle.

Consider the economic inflation in 2006 thus far with multiple interest rate increases by the federal reserve bank causing inflationary pressures amid inflationary concerns, 2007 seems reasonable to repeat this year's economic trend.

Consider the growing professional body of physical therapists with nationally recognized speciality and post graduate credentials applying evidenced based research into daily practice, the depth and breath of clincal knowledge expands proportional to the costs of pre and post graduate education and time.

Now, consider the five year review proposes to reduce the conversion factor in the current fee schedule which arguably rejects the aforementioned considerations.

Clearly, this is an arguement to increase the RVU conversion factors and increase physical therapy CPT code reimbursement. Moreover, tacit inference can be drawn to consider highly skilled physical therapists as relating to higher RVUs.

Rebuttle is welcome.