Submitter : **Mrs. Alicia Garner** **Date: 08/10/2006**

Organization : **Garner Physical Therapy Center, LLC**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

My name is Alicia Garner and I am the owner of a private practice physical therapy clinic as well as a physical therapist. I started this practice 3 years ago to serve an unmet need in the retirement capital (aka Sun City Center) of the Tampa Bay area. MANY seniors suffer in silence from urinary and bowel incontinence and my passion is to help them through physical therapy. We have been very successful in helping our patients return to an active lifestyle, where before they were imprisoned in their homes, afraid to go out into public for fear of accidents. We provide many different types of therapy at a high standard of care to our patients and they routinely express deep gratitude for the type of treatment they receive in our clinic. Roughly 85% of our patients are on Medicare due to the area we are located in. I have 5 employees that help me provide this high level of service.

I would like 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 RVUs under the Medicare physician fee schedule. I am urging you to ensure that these severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. I strongly recommend that CMS transitions the proposed changes to the work relative value units (RVUs) over a four year period to ensure that patients continue to have access to valuable health care services, such as they receive in our clinic.

Why transition?

Currently the Sustainable Growth Rate (SGR) formula is projected to trigger a 4.6% cut in payments in 2007. Similar cuts are forecast for the foreseeable future, totaling 37% by 2015. Costs however are not decreasing; they are increasing at just as quickly a pace as the cuts are. The impact of these cuts would be further compounded by a budget neutrality adjuster proposed in the 5-year review rule that would impose additional cuts on top of the SGR. It is unreasonable to propose policies that pile cuts on top of cuts.

Medical clinics such as ours are being squeezed at both ends. On the one hand, costs are increasing. The salaries for in-demand physical therapists are increasing, malpractice insurance premiums are increasing and overhead costs go up each year such as rising electric bills due to the high cost of fuels. On the other hand, reimbursements are dropping. This leaves an increasingly smaller amount with which to cover these increasing expenses.

Physical therapists cannot bill for E/M codes and will derive no benefit from those increased payments. This will cause 2007 to be a devastating year for physical therapists and other non-physicians who are not allowed to bill for E/M services. CMS emphasizes the importance of increasing payment for E/M services to allow physicians to manage illnesses more effectively and therefore result in better outcomes. Increasing E/M payments is important, but the value of services provided by all Medicare providers should be acknowledged under this payment policy. Physical therapists spend a considerable amount of time in face-to-face consultation and treatment with patients, yet their services are being reduced in value.

These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment for these services is cut so severely, access to care for millions of the elderly and disabled will be jeopardized.

Thank you for considering my comments in your decision.

Sincerely,
Alicia C Garner, PT & Owner
Garner Physical Therapy Center, LLC

Submitter : **Mrs. Rhonda Ludwig** **Date: 08/10/2006**

Organization : **Garner Physical Therapy Center, LLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Other Issues

Other Issues

My name is Rhonda Ludwig and I am a physical therapist assistant practicing in a therapist owned private physical therapy clinic in Sun City Center, FL. We offer very specialized care to the MANY seniors that suffer in silence from urinary and bowel incontinence. Imprisoned in their homes and afraid to go out into public for fear of accidents, we have been very successful in helping them return to an active lifestyle. Our patients routinely express deep gratitude for the type of treatment they receive in our clinic because we strive to provide a very high quality of hands on care. Roughly 85% of our patients are on Medicare due to the area we are located in.

I would like 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 RVUs under the Medicare physician fee schedule. I urge you to ensure that these severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. I strongly recommend that CMS transitions the proposed changes to the work relative value units (RVUs) over a four year period to ensure that patients continue to have access to valuable health care services, such as they receive in our clinic.

My reasons for requesting a transition period include the following:

Currently the Sustainable Growth Rate (SGR) formula is projected to trigger a 4.6% cut in payments in 2007. Similar cuts are forecast for the foreseeable future, totaling 37% by 2015. Costs however are not decreasing; they are increasing at just as quickly a pace as the cuts are. The impact of these cuts would be further compounded by a budget neutrality adjuster proposed in the 5-year review rule that would impose additional cuts on top of the SGR. It is unreasonable to propose policies that pile cuts on top of cuts.

These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment for these services is cut so severely, access to care for millions of the elderly and disabled will be jeopardized.

Physical therapists cannot bill for E/M codes and will derive no benefit from those increased payments. This will cause 2007 to be a devastating year for physical therapists and other non-physicians who are not allowed to bill for E/M services. CMS emphasizes the importance of increasing payment for E/M services to allow physicians to manage illnesses more effectively and therefore result in better outcomes. Increasing E/M payments is important, but the value of services provided by all Medicare providers should be acknowledged under this payment policy. Physical therapists spend a considerable amount of time in face-to-face consultation and treatment with patients, yet their services are being reduced in value.

Dr. McClellan, thank you for considering my comments in your decision.

Sincerely,

Rhonda Ludwig, PTA
Garner Physical Therapy Center, LLC

Submitter : Dr. Alan Yager

Date: 08/10/2006

Organization : Dr. Alan Yager

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

CMS created this idea of a non-work pool for codes with only technical costs. If the idea was to shield the codes from significant reductions, it did not work. The technical side to CPT code 93701, which is used in my practice, is going from 0.66 includes malpractice. That amount is crazy when you consider the costs of performing the test. CMS must be using old data. Please research and revise the data to more updated costs.

Submitter : Dr. Scott Schmidt

Date: 08/10/2006

Organization : Dr. Scott Schmidt

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

It is reasonable for CMS to move to a bottoms up approach to valuing practice expense RVUs using actual cost data, which differs significantly from one piece of equipment to another. If different equipment prices are being used, it would then be appropriate to consider different utilization rates for each procedure. This would not take a survey or market data, as CMS knows the utilization rates for each procedure.

Submitter : **Dr. Jessie Cockrell** **Date: 08/10/2006**

Organization : **Cockrell Family Medicine Center**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Practice expense values for CPT codes 93000, 93701, and 93 701-TC are way too low.

Submitter : **Dr. Michael Washinsky** **Date: 08/10/2006**

Organization : **Dr. Michael Washinsky**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Do not reduce the practice expense values immediately for equipment that has been purchased based on prior reimbursement levels. Please delay the implementation start for the new RVUs until equipment purchased last year has been largely paid for. This would be 4 years from now, or to start in 2010. Then you could phase it in immediately if you want. That would give people considering new purchases the knowledge to make informaed decisions, and would not punish decisions made based on reimbursement rates that were subsequently scheduled to go down substantially.

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

Organization : glenwood medical associates

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 currently the only iscd certified densitometrist in our community and am extremely disheartened by the threatened cuts
to dxa reimbursement.
As the osteoporosis referral center in our community and surrounding 90 mile radius, this will effect our practice and our community drastically.
given the cost of our ge lunar device, the cost of staying credentialed and hiring and keeping trained technichians, this change will dramatically effect our ability to continue treating patients with cost effective measures. In addition, instead of preventing thousands of fractures, the cost of disability associated with treating these fractures will be astronomical.
Diagnosing and treating osteoporosis saves millions of medicare dollars. Without dxa scans and appropriate reimbursement, it will be difficult for us to continue to do this.

Submitter : **Mr. Burton Segal** **Date: 08/10/2006**

Organization : **Riverpoint Psychiatric Associates**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

Expenses of running a practice have steadily increased. Medicare reimbursements are extremely low. The proposed 14% cut in reimbursement for Social Workers will reduce our ability to serve patients adequately and our practice may have to consider discontinuing to be medicare providers. I strongly urge CMS not to reduce work values by 7% for Clinical Social Workers. I request that CMS withdraw the proposed increase in evaluation and management codes until they have funds to increase reimbursement for all medicare providers. Further I would request that CMS not approve the proposed 'top down' formula to calculate practice expense and that they select a formula that does not create a negative impact on mental health providers.

Submitter : **Dr. STAN MAYS** **Date: 08/10/2006**

Organization : **MAYS CLINIC**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I am a solo practice physician and I purchased a dexa machine approximately 5 years ago because I realized the need for women in my practice to have the availability of osteoporosis screening.Having it in my office increases compliance and followup.This proposed drastic reduction in reimbursement will greatly decrease the access of osteoporosis screening because providers will not be able to afford the cost of a dexa machine to provide screening in their offices.Is the cost and maintenance of a fan beam dexa scan machine taken into consideration when making cuts? Please reconsider your reduction on this screening because I think it will have a negative impact on the women needing this service.

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

Organization :

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

The services social workers provide are invaluable.

Submitter : **Dr. robert sarnataro** **Date: 08/10/2006**

Organization : **robert sarnataro md**

Category : **Physician**

Issue Areas/Comments

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

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

In reference to CMS-1512-PN

The proposed payment reduction for DXA imaging is unrealistic and in no way reflective of the costs involved in accurate DXA imaging.

The cost of the hardaware and technician services far exceed the revenue that would be generated at the new fee schedule.

If the reduced fees are approved, it would be financially imposssible to continue to provide DXA services to my patients, and impact upon DXA availability.

The cost of hip fractures would negate any savings resulting from decreased DXA reimbursment.

Sincerely,
Robert Sarnataro, MD

Submitter : **Mrs. Pamela Gall** **Date: 08/10/2006**

Organization : **Radiologic Technologist**

Category : **Other Technician**

Issue Areas/Comments

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

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

Commenting on the Medicare,Medicaid reduction of reimbursements for DXA studies. I feel this decrease will reduce the availability of good quality BD testing. In doing that a decline in quality osteoporosis care will follow. In the long run Medicare/Medicaid will end up paying more for hip fractures and spinal compression fractures.

Submitter : **Mrs. Roxanne Peterson** **Date: 08/10/2006**

Organization : **Great Falls Clinic**

Category : **Other Technician**

Issue Areas/Comments

Other Issues

Other Issues

I am concerned that the proposed changes in the Medicare reimbursements will have a profound effect on womens access to osteoporosis screenings. Preventative medicine is the best source we have for combating the huge drain that osteoporotic fractures could have on our future health care system.

Submitter : Ms. Shanna Nispel **Date:** 08/10/2006

Organization : COMCARE/USD 259

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

Please maintain or raise current reimbursement rate for Clinical providers. A 14 percent reimbursement cut will effect everyone's practice, including the people we serve. Finding high quality professionals who are able to take Medicaid clients becomes more and more difficult and with rate cuts, access to services is severely limited.

I am also requesting that CMS not reduce work values by 7% for clinical social workers effective January 1, 2007 and that you withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers. Please DO NOT not approve the proposed "Top down" formula to calculate practice expense.

Please DO select a formula that does not create a negative impact for mental health providers or their clients.

Submitter : **Dr. Gary Holden** **Date: 08/10/2006**

Organization : **Medi-Help**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Your inputs for practice expense for one procedure I am familiar with are incorrect. For CPT 93701, the equipment cost is $36,000, not the $28K figure quoted from the tables.

Submitter : Dr. Milene Janicijevic **Date:** 08/10/2006

Organization : Medi-Help

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The examples given in the document 1512 for the formulas for common procedures is good, but it needs to be made available for all procedures that are significantly reduced. I cannot figure out why some codes I use have been reduced while others have not.

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

Organization : **LSCSW Psychotherapist, private practice**

Category : **Social Worker**

Issue Areas/Comments

Other Issues

Other Issues

With the proposed decrease in fee reimbursement for Social Workers, I respectfully request that you not decrease an already low reimbursement for Social Work services. Many times, treatment with a Social Worker prevents more drastic and expensive interventions for clients on down the road. Many fine Social Workers will drop out of service delivery if the fees are reduced further. This would be bad for the client and the various healthcare delivery systems.--Susan Sanders, LSCSW, 7451 Switzer Rd. Suite 118A, Shawnee Mission, Ks. 66203

Submitter : **Dr. obinna oriaku** **Date: 08/10/2006**

Organization : **crown clinic pa**

Category : **Physician**

Issue Areas/Comments

Background

Background

The proposed changes to the current re-imbursement for osteoporosis screening will hamper utilization of a very important tool and negatively impact much of the progress made in women's health issues over the years.

I am writing to support efforts to keep re-imbursements as they are and quite frankly, to consider incentives to increase utilization of this critical tool.

Submitter : **Dr. Audrey Kriegman** **Date: 08/10/2006**

Organization : **Dr. Audrey Kriegman**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment on proposed changes to the 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. The cost of purchasing and upgrading machinery and staff time in scheduling and preparing the patients would not be adequately covered by the current recommended reductions in reimbursement. Please reconsider and provide physicians with a reasonable compensation for their time and efforts.

Submitter : **Ms. Laurel Brown** **Date: 08/10/2006**

Organization : **ARC Broward**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

A 14% reduction in reimbursement fees will mean that my organization will no longer be able to see Medicare clients for therapy or medication management. This will mean many Medicare recipients will not be able to access mental health services. Please do not reduce Social Worker work values by 7%. Please withdraw the proposed increase in evaluation and management codes until there are funds to increase reimbursement for all Medicare providers. Please
do not approve the proposed Top down formula to calculate practice expense. Instead select a formula that does not create a negative impact for mental health providers. Social Workers already provide excellent services for lower costs than other professions.

Submitter : **Mr. Albert Linder** **Date: 08/10/2006**

Organization : **National Association Of Social Workers**

Category : **Social Worker**

Issue Areas/Comments

Other Issues

Other Issues

The reimbursement rates for mental health services provided by Medicare are already well below reasonable and standard rates for this area. Any attempt to further reduce the fee schedule will reduce the availability for needed services for disabled and retired citizens. Professionals cannot afford to take up the slack for the Medicare program. Many already reject patients who do not have suplimental insurance...Thank you...

Submitter : **Dr. Michael Nosler** **Date: 08/10/2006**

Organization : **University of Nebraska Medical Center**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

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

To whom it may concern:

I am a practicing gastroenterologist in Omaha, Nebraska. Thank you for the opportunity to comment regarding the proposed changes to the Physician Fee Schedule for 2007.

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

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

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

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

Thank you for your consideration of my comments.

Sincerely,
Michael J Nosler, MD

Submitter : Chris McKee

Date: 08/10/2006

Organization : Chris McKee

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

Giving physicians an increase in reimbursements on the back of other health professionals merely continues to bandaid a dysfunctional system. People are leaving health care due to this type of mis-'managed care'. Robbing peter to pay paul never ads up and guarantees this issue continues without respite.
Please consider an attempt to reconcile these discrepancies, and don't just pass the buck to the next committee.

Submitter : **Ms. Gillian Morris** **Date: 08/10/2006**

Organization : **Ms. Gillian Morris**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I believe that it would be a grievous error to pass this proposal for 2007. We social workers are already struggling to serve a vulnerable population despite our limited resources and high caseloads. The less we are reimbursed, the less care the mentally ill will receive and therefore the less likely they are to go on to lead productive lives. I request that CMS withdraw the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Medicare providers. I also request that CMS not approve the proposed formula to calculate practice expense, but instead select a formula that does not create a negative impact for mental health providers. Thank you.

Submitter : Dr. Joseph Laukaitis **Date:** 08/10/2006

Organization : Dr. Joseph Laukaitis

Category : Physician

Issue Areas/Comments

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

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

Re: Proposal to significantly reduce reimbursement for DXA scans (CPT 76075) and VFA (Vertebral Fracture Assessment- CPT 76077). I am a rheumatologist practicing in Washington, DC. for close to 20 years. My practice consists of many patients with Osteoporosis and many more at risk of developing Osteoporosis because of underlying chronic rheumatic disease and exposure to medications that can cause loss of bone density. I do not own a DXA scanner or perform the above procedures. I rely on my Medicare patients being able to have their bone density measured and followed by private physicians and radiology groups who have DXA scanners. The detection of Osteoporosis and Osteopenia has been a valuable advance in the care of elderly and chronically ill patients. I am seriously concerned that that this proposed decrease in reimbursement levels will discourage practitioners from purchasing and maintaining these expensive scanners. Some physicians may simply refuse to provide this service to Medicare patients. The result will be limited access to this important measurement tool for my Medicare patients. They are already facing a reduction in access to certain types of medical care because of primary care providers opting to not participate in Medicare. This reduction in reimbursement would ironically come at a time when there is a major push by health agencies to increase detection and treatment of Osteoporosis in the elderly. Significant cost savings are achieved by reducing fractures in this population. I would like to point out that inaccurate assumptions were made in the calculation of the proposed rates. 1.The practice expense (technical component) was calculated assuming the equipment expense of a pencil-beam densitometer($41,000) when most machines now use fan-beam technology ($85,000). 2.Equipment utilization rate was assumed to be 50% based on use of DXA machines in high-volume radiology centers. At least half of my patients have their DXA scans performed in the comfort of their physician's office, where the equip. utilization rate is closer to 20%. 3.Apparently CMS concluded that the physician work component for interpreting DXA scans has become more mechanical and less skilled. I beg to disagree, having to occasionally re-interpret DXA scans at the request of my patients and other physicians. A high quality report requires review of multiple factors and often comparison to previously performed DXA scans. This is a complex study - especially in the elderly with multiple risk factors and overlying problems such as degenerative arthritis. Please re-consider these proposals. I truly believe they will interfere with future access to this important technology that ultimately reduces costs to our society. Sincerely yours, Joseph P. Laukaitis, M.D. (202-293-8855 - drlauk@verizon.net)

Submitter : **Dr. Tom Scaletta** **Date: 08/11/2006**

Organization : **American Academy of Emergency Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : **Mr. Tim Brown** **Date: 08/11/2006**

Organization : **Bradford Hospital**

Category : **Hospital**

Issue Areas/Comments

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

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

I am very concerned with you proposal to reduce technical reimbursement for DXA. I am a Imaging Services Director and I can comment from professional experience that these units with Fan beam technology are not only much more expensive than pencil beam, but more costly to maintain. They also provide far better results than a simple finger unit or pencil beam unit. By passing such a cut, you would be forcing facilities to settle for a inferior piece of equipment that would give less quality and no means for tracking progress on treatment. In the long run, I believe this could end up costing more money for extensive surgeries due to under or non diagnosed problems. We as a facility are asking that you reconcider your plan. Thank you

Submitter : **Mr. Keith Borders** **Date: 08/11/2006**

Organization : **Mr. Keith Borders**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

As a LCSW working in a community mental health setting, this will cut down on the already meager funds we use to serve those that cannot afford needed mental health treatment through the private practice setting.
Reducing work values for social workers will emphasize the misconception that the work done in our field is less valuable than that provided by our colleagues in the health care field.
I would also like CMS to withdraw the proposed increase in evaluation and management codes until you are able to increase reimbursement for all Medicare providers. Lastly, the proposed 'top down' formula for calculating practice expense is inherently unfair and discriminates against those who are providing mental health care. Thank you for considering my comments, and I hope you take the time necessary to make a decision which will benefit the general public, not just a select few.
Sincerely,
Keith A. Borders, LCSW

Submitter : **Barbara Roddenberry** **Date: 08/11/2006**

Organization : **Barbara Roddenberry**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I respectfully request that CMS not reduce work values by 7 % for clinical social workers effective January 1, 2007 and that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and CMS not approve the proposed Top down formula to calculate practice expense. CMS should select a formula that does not create a negative impact for mental health providers. LCSW's are highly trained professionals and should be regarded as such. Social Workers provide quality services and should be compensated appropriately.

Submitter : Mr. Dean Vines LCSW **Date:** 08/11/2006

Organization : Associates of Hampton Roads

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed reduction in fee payments and cost of business allowance to out patient psychotherapist or any medical professional is unjust, penny wise and pound foolish. Most of my colleagues will not accept medicaid/medicare based on current fees. This will force me into their ranks. My primary care physician does participate either. Costs of doing business continue to rise. Many of the best brightest and most experienced psychotherapist and physicians are leaving their fields of practice do not being able to support their families.
The cost of a one hour unit of care goes beyond the hour scheduled for the individual. A medicaid or medicare provider must face the risk of financial ruin due to look behind audits that deny payment for quality services provided in good faith. One needs to be a lawyer to effectively document services to a degree that reduces this risk.If medicaid or medicare patients do not show then that is an hour of income lost. These are the patients most likely to make frequent weekend and evening crises calls that up more non-billable time. The time spent with the mind numbing paper work and efforts to deny claims based on semantics in treatment reports is billable time lost. For example: A claim was denied because I used the word therapy instead of psychotherapy in the treatment report. I am an LCSW. Did they think I was doing physical therapy? I recently switched to a practice with lower overheard(Where none of the therapist take medicaid patients incidently). I have submitted a complete medicare provider application for the location three times on the form TrailBlaser(contractor) and CMS sent. It has been returned three times. The last time I was informed that it was on the wrong form since they were revised in June 06. This has been going on since March 1, 2006. I have been a provider since the early nineties. Given a choice of less pay for more work, risk and stress would you the reader be a medicaid provider?

I am well trained and experienced(20+ years) in work with children and families that need our services the most. They are the reason I began this career. They should not be deprived of services equal in quality to those available to folks with money/ real insurance. I am worried as a provider and a potential future medicare consumer. Folks will be hurt due to availability of only substandard care or no care at all. The reader or her/his family will likely be negatively impacted in the future. I have taken severe pay cuts over the last years while drug and managed care companies have seen profits soar.

The greed and pandering to the drug and insurance company lobby that lead to these proposed cuts will cause a political backlash that will be hard for the those in office to fight.
Please note that I am contacting every senator and congressman with my concerns. My colleagues are doing the same and we vote and influence others.

Submitter : Dr. Frances Ryan **Date:** 08/11/2006

Organization : Dean Health Care

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

What are you trying to do to the field of Medicine? Do you really believe that there is fat to cut in the primary care specialties? Or, are you assuming that people will continue to see Medicare patients, nay stay in Medicine, out of the goodness of their hearts?

When insurance over head is running in the double digits what are you doing cutting doctor's pay. Maybe if the head of United Health Care was not taking a billion dollars out of his company, money that could have gone to actually paying their patient's bills and providing services, physicians could afford to see Medicare patients. If the health care dollar actually stayed in health care every patient would benefit.

Jeff Whittle
2716 E.Newtom
Shorewood, WI 53211

July 10, 2006

C, ry

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

Re: Public Comment on proposed update on E/M services

Dear sirs:

I am writing to support the proposed changes in the RVU value for the E/M codes for initial, and follow up hospital and inpatient services. As someone who recently was trying to make a University based general internal medicine division solvent, I feel I have a good perspective. For the last year, because of a change in academic institution, I am a VA employee, and am no longer directly affected by these changes, but I am very familiar with the issues. I can tell you that it was unequivocally impossible for my group of 8 general internists to make a profit seeing patients for whom we could bill solely for evaluation and management services (since the institution provided all lab, radiology and cardiology testing). Thus, it is not surprising that many private practices are forced to concentrate mightily on providing better reimbursed ancillary services. I personally thought hard about providing duplicative bone mineral density testing, point of service blood work, and EKG's, simply because we wanted to capture the revenue that otherwise went to the hospital or subspecialty colleagues. Although this duplication would clearly have increased costs to Medicare, and decreased the overall profit of the institution, we were in a constant battle for survival.

This battle for survival also pushed us to consider forcing patients to return for brief visits (easily documented as 99213 level visits) simply to confirm a response to an increase in BP meds, review recurrent labs (most egregiously INR monitoring) or refill drugs.

With these observations in mind, I was absolutely thrilled to see the consideration that a more equitable distribution of reimbursement will be made that will support people who simply want to provide excellent coordinated care to sick people. I think that good care of these people involves telephone support of routine questions, mailed lab results, non – MD (but trained professional) assistance in counseling regarding a host of issues that are best addressed in the context of a symptom initiated visit, and so on. Thus, when I see a patient with diabetes and atrial fibrillation, I might commonly spend a long visit reviewing home glucose and BP logs, discussing the cost issues involved in obtaining medications, consult with another health professional monitoring the warfarin therapy, and then address whatever other issues might arise. Both the patient and I

would prefer that much of the follow up of the impact of changes on glycemic and blood pressure control be by phone. The decision about how many issues we can address at a visit, and how frequent follow up needs to be, should be a clinical decision between the patient and I, not a decision dictated by reimbursement. Similarly, the decision whether to obtain a "routine" EKG for all diabetics, or to screen annually with a relatively low accuracy heel densitometer, should not be driven by the observation that this sort of service can convert a money losing visit to a breakeven one. The proposed changes will allow internists to make the right choices and still stay in business.

Now, I also recognize, as I am sure you do, that these change in E and M coding will not cause people who are focused on maximizing income to suddenly become motivated solely by what makes the most sense clinically and for the patient's perspective. They will benefit just as much as those who are purely clinically driven and will no doubt continue to practice in an expensive way that maximizes every other kind of income as well as benefiting from these changes. Thus, the same changes that will make financial survival possible for hard working, E and M focused, family practitioners and GIM docs will be pure gravy for those who have already devised systems to take advantage of the current rules. Thus, there is no way (at least that I can see) to make sure that these increases target the people who need them. Indeed, there are many general surgeons practicing in under-resourced areas who need payment relief far more than the generalists who have figured out how best to supply those ancillaries that are highly profitable. I am hopeful that you will continue to work with the ACP on the medical home concept in a way that will reimburse high quality primary care without overpaying people who skillfully craft notes to maximize reimbursement, while minimizing costly under-reimbursed services like telephone support and nurse only visits for follow up and discussion of BP, HgbA1c, or INR.

Thank you for your time and attention. Good luck with your difficult job. This is a very important first step. Feel free to call me if you want to confirm this is not a form letter. I am CCing my Representative, Jim Sensenbrenner, and Senators, Herb Kohl and Russ Feingold. I am hopeful that they will stick with you as the suppliers of procedural services try to argue against these needed payment reforms.

Sincerely,

Jeff Whittle, MD, MPH
414-332-2949

Jeff Whittle
2716 E.Newtom
Shorewood, WI 53211

July 10, 2006

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

Re: Public Comment on proposed update on E/M services

Dear sirs:

I am writing to support the proposed changes in the RVU value for the E/M codes for initial, and follow up hospital and inpatient services. As someone who recently was trying to make a University based general internal medicine division solvent, I feel I have a good perspective. For the last year, because of a change in academic institution, I am a VA employee, and am no longer directly affected by these changes, but I am very familiar with the issues. I can tell you that it was unequivocally impossible for my group of 8 general internists to make a profit seeing patients for whom we could bill solely for evaluation and management services (since the institution provided all lab, radiology and cardiology testing). Thus, it is not surprising that many private practices are forced to concentrate mightily on providing better reimbursed ancillary services. I personally thought hard about providing duplicative bone mineral density testing, point of service blood work, and EKG's, simply because we wanted to capture the revenue that otherwise went to the hospital or subspecialty colleagues. Although this duplication would clearly have increased costs to Medicare, and decreased the overall profit of the institution, we were in a constant battle for survival.

This battle for survival also pushed us to consider forcing patients to return for brief visits (easily documented as 99213 level visits) simply to confirm a response to an increase in BP meds, review recurrent labs (most egregiously INR monitoring) or refill drugs.

With these observations in mind, I was absolutely thrilled to see the consideration that a more equitable distribution of reimbursement will be made that will support people who simply want to provide excellent coordinated care to sick people. I think that good care of these people involves telephone support of routine questions, mailed lab results, non – MD (but trained professional) assistance in counseling regarding a host of issues that are best addressed in the context of a symptom initiated visit, and so on. Thus, when I see a patient with diabetes and atrial fibrillation, I might commonly spend a long visit reviewing home glucose and BP logs, discussing the cost issues involved in obtaining medications, consult with another health professional monitoring the warfarin therapy, and then address whatever other issues might arise. Both the patient and I

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