Submitter : **Dr. Mark Wilson** **Date: 08/15/2006**

Organization : **Sansum Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs

This is regarding the proposed decrease for medicare reimburesement for DXA scaning for osteoporosis screening and surveillance. As a physician who routinely orders DXA scans, and finds great value in the information provided, I see no doubt that such a drastic cut in reimbursement will decrease access to this valuble clincial tool.

If the physician reimbursement is decreased, MDs will no longer have financial incentive to offer the test. Please reconsider this proposal, as DXA screening has improved our treatment for this lifethreatening condition.

Mark Wilson, MD
(805) 681-7623
Sansum Clinic
Santa Barbara, CA

Submitter : **Ms. Barbara Ziff** **Date: 08/15/2006**

Organization : **Ms. Barbara Ziff**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

As a social worker, I am against the proposed 14% cut in payments to social workers. It appears that a better solution would be to create a formula that does not create a negative impact for clinical social workers who have little practice expense as providers.

Submitter : **Ms. Deborah Jervis** **Date: 08/15/2006**

Organization : **Ms. Deborah Jervis**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am a licensed clinical social worker providing therapy to elderly clients. A 14% decrease in Medicare reimbursement will force me to reconsider serving the elderly client. While working with the elderly is my expertise and my committment, I must earn enough to support the expenses of a private practice and to provide a livelihood for myself.
If there is a decrease in Medicare reimbusrsement, a concern is that current mental health practitioners with expertise in the complex issues of the older adult will not be able to continue to serve this population. That will leave fewer mental health practitioners for the Medicare recipient to access. It is also likely that less qualified and less skilled practitioners will be providing services to our aging population.
In addition to my private social work practice, I work in an out patient medical clinic that serves patients on Medicare. A high percentage of our patients suffer from depression. We would not be able to comprehensively treat this disease without skilled mental healthcare paractitioners (psychologists and social workers), with training in geriatics, who accept Medicare. Our typical patient has little or no income beyond Social Security and cannot afford to pay privately for counseling. Adding counseling to medication has allowed our patients to successful combat depression. Elderly patients commonly express depression through somatic complaints. When depression is lowered, general health complaints go down, and fewer Medicare dollars are spent on non-specific medical concerns.
Please do not reduce work values by 7% on January 1, 2007. Please reconsider the top down formula to calculate practice expense. Please adopt a formula that does not create a negative impact for mental health providers.
Our government and our society has an obligation to care for our elderly. By making it more difficult for skilled practioners to provide quality care, we risk abandoning the well being our our elders.

CMS-1512-PN-1520

Submitter : Mrs. Marsha Vaughn

Date: 08/15/2006

Organization : Mrs. Marsha Vaughn

Category : Individual

Issue Areas/Comments

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

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

I AM OPPOSED TO THE REDUCTION IN PAYMENT FOR DEXA SCANS. THIS IS OUTRIGHT ROBBERY. YOU EXPECT ANYONE TO DO THESE TEST FOR FREE. THAT IS JUST WHAT YOU ARE DOING. AS AN X-RAY TECH. THIS WOULD NOT EVEN PAY MY HOURLY WAGE. NO DOCTOR OR ANY OTHER FACILITY WILL DO THIS TEST THAT IS SO VITAL TO POSTMENOPAUSAL. MAYBE WE WILL ALL BE IN NURSING FACILITIES WHEN THIS GOES THROUGH AND YOU CAN PAY THE BILL FOR THAT. PLUS OUR THERAPY AND PROSTHETICS.
MARSHA VAUGHN X-RAY TECH.

Submitter : **Virginia Ives** **Date: 08/15/2006**

Organization : **Family Wellness Counseling, LC**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

I believe it is WRONG to make a cut of 14% for reimbursement to mental health providers. Regardless of the allowed amount the reimbursement is under $40. It ranges from $32 to $36. for a LCSW. I am afraid any cut will cause more providers to stop accepting Medicare and our senior population will suffer.

There actually should be an INCREASE in reimbursement so more seniors could find professionals to help with mental or emotional issues. It is a fact that when depression is treated people are healthier and heal better.

This is a country that should be providing for the young and old, not dienfranchising them from services that can improve their health and quality of life.

Sincerely, Virginia A Ives, LCSW

Submitter : **Dr. Robert Whitcomb** **Date: 08/15/2006**

Organization : **Elmhurst Anesthesiologists**

Category : **Individual**

Issue Areas/Comments

Practice Expense

Practice Expense

221 Church Road
Winnetka, IL 60093

August 15, 2006

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

Dear Sir or Madam:

In the June 29 Federal Register CMS proposed a new practice expense methodology, as well as changes in work values stemming from the recently conducted Five Year Review. This is estimated to be a 6% cut in total payments to anesthesiologists due to the Five Year Review and an additional 1% cut every year through 2010 due to the practice expense changes. This would amount to a 10% cut in Medicare payments to anesthesiologists over the next four years.

I am writing to strongly protest these proposed changes. 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. A comprehensive multi-specialty practice expense survey is desperately needed. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.

In addition 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.

Sincerely,

Robert Whitcomb, MD

CMS-1512-PN-1522-Attach-1.DOC

Attach
#1522

221 Church Road
Winnetka, IL 60093
whitcombrobert@yahoo.com

August 15, 2006

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

Dear Sir or Madam:

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CMS should gather NEW overhead expense data to replace the decade-old data currently being used. A comprehensive multi-specialty practice expense survey is desperately needed. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.

In addition 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.

Sincerely,

Robert Whitcomb, MD

Submitter : **Dr. George Heffner Jr** **Date: 08/15/2006**

Organization : **-**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I am currently an Internist practicing in a small community. i have additional training in Cardiology and practice in a multispecialty group with 15 physicians. I am writing because I was and continue to try to be an idealist. When i decided to go into medicine, I believed that if I took good care of my patients practicing quality, cost effective medicine with only the patient's best interests in mind, that i would be successful. I have learned, however, that it doesn't pay to do that. I see 7500 patients a year and work 75 hours a week, yet I struggle financially. I have colleagues who avoid seeing patients as much as possible and make a large amount of money by performing questionable tests and procedures. They might perform a $2000 test or procedure so that they can make $200 more. Why? Because the government has decided to pay much more to do rather than to think. This has resulted in massive cost overruns. Heck, why kill yourself seeing 40 patients a day, when you can sit in a quiet room with a cup of coffee reading 10 studies in an hour and a half and make more money?

If the government is serious about reform this time, it is important that proposals to change the system to pay more to see patients not get so watered down so as to be meaningless. The writing is on the wall. No one wants to do primary care. Primary care doctors of the future will soon be only foreign medical grads, allied health professionals, and non-MDs.

I realize that money is scarce and exchanges need to be made so I'll offer a list of some relatively overpaid services;

-Imaging studies, both the technical and professional componets are overpaid particularly nuclear studies and MRI's- that's why we have so many of these
-Pain Medicine injections are ridiculously overpaid. A specialty was created overnight by Medicare. It stole anesthesiologists and rehab docs and created a bunch of narcotic pushers
-Cataract surgery takes 10 minutes, less than pulling a tooth. Retina laser procedures are even worse
-Dermatologists earn more money/hour than any other doctors-is what they do that important?
-What does a Urolgist do in an office vist to justify higher payment than primary care? How many questions are there to ask and what is there to be examined? We have a urologist who when consulted writes either "foley draining well" or "patient passing water" every day without seeing the patient. You pay this as well as the person actually caring for the patient!
-Radiation Therapy requires very little physician work and rarely involves nights or weekends
-About 1/3 of births are now by C section. Csections pay better than vaginal births and are often scheduled. I wonder if a correlation exists?
-Medicare should purchase the drugs it will now pay for office administration
-Virtually all procedures performed by an ENT are of questionable medical value
-All nursing home patients are initially "skilled care" for as long as possible. If they are admitted to a hospital and sent back even a day later, they are "skilled" again

I could go on and on. I know politics will not never allow a perfect world, but I hope you can make some difference this time. Thanks

Submitter : **Dr. Patricia Hoffmann** **Date: 08/15/2006**

Organization : **Iowa Medical Society, American Soc of Anesthes.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern:

I practice anesthesia in Des Moines, Iowa. My state is sixth in quality outcome measures for Medicare and 48th in Medicare reimbursement. The proposed cuts in Medicare payments to anesthesiologists will make participation in Medicare nearly impossible.

The change in practice expense methodology hurts anesthesiology more than most subspecialties, because data used by CMS to calculate overhead expenses is outdated and underestimates actual expenses. Please consider collecting new data.

Another injustice in Anesthesiology is the anesthesia teaching rule. This puts our academic centers who train anesthesiologists in jeopardy. The gross underfunding of departments who train resident in anesthesiology is appauling.

Please consider reversing the anesthesia teaching rule and proposed Medicare cuts.

Thankyou for your time

Patricia Hoffmann DO

Submitter : **Mr. jeremy Tilawen** **Date: 08/15/2006**

Organization : **Swope Health Services**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Practice Expense

Practice Expense

Cutting medicare expense would be catastrophic for my clients. medicare has already been cut and medicare is still the lowest paying insuarance and cutting more benefit makes no sense at all. Please hear the requests from my clients.

Submitter : Ms. Linda Loveall

Date: 08/15/2006

Organization : Ms. Linda Loveall

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

Under the proposed budget cuts to clinical social workers, I want to go on record to oppose the cuts.

Submitter : **Date: 08/15/2006**

Organization :

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

I ask that there will be no cuts by CMS to the social workers practice costs. With rising costs of gas, my practice will suffer without ability to offset those costs for homebound clients. IN addition, it will be extremely difficult to see clients who are not able to afford co-pay and/ or have a sliding fee scale. Most of the elderly and disabled who seek my counseling services are well beyond Poverty limit, and some have No Medicare. Seeing these individuals would be next to impossible, if the 14% cuts are implemented. Please, holt the decrease in payment, for in our field of Social work, professionals are already underpaid and lack Medicaid Reimbursement when providing services to elderly.

Submitter : **Mrs. Carolyn Wampler** **Date: 08/15/2006**

Organization : **Family Therapy of the Ozarks**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

Our rates are far below market and make it difficult to serve the medicare patient already. Cutting reimbursement rates for those who serve the senior citizens is not an appropriate way to balance the budget.

Submitter : **Mrs. Karen Eagley** **Date: 08/15/2006**

Organization : **east valley diagnostic imaging center**

Category : **Health Care Industry**

Issue Areas/Comments

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

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

We at our outpatient clinic are concerned about the possible upcoming Medicare cut planned for Bone Densitometry. What ever we can do to stop this from happening would be our honour.

Submitter : **Ms. Barbara Hicks** **Date: 08/15/2006**

Organization : **Self employed-In-Home Therapist**

Category : **Social Worker**

Issue Areas/Comments

Other Issues

Other Issues

I am a Licensed Clinical Social Worker living alone. It is very important to my well-being to not have a pay cut. When we have clients that are sick, no-show or cancel for various reasons, this also is an unexpected cut. I am a social worker because I love the work. I would hate to think about needing to change professions due to my pay. Please consider these things when making your decision about a pay cut. Thank you.

Submitter : **Mrs. Aneisa Sherrill-Mattox** **Date: 08/16/2006**

Organization : **No organization or affiliation**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam:

It is reprehensible and morally wrong to continue punishing the poorest of the poor and with the proposed cuts that will be exactly what you are doing. How many times are you going to continue to cut back on social programs? Have you ever been into a Community Mental Health Center and see what they do? Have you ever seen a woman so stricken with mental illness, so deep in depression, cut her wrists and arms in an attempt to relieve the overwhelming emotional pain that she is in? Have you ever seen someone with schizophrenia plagued with hallucinations and delusions not take their medication because they can't afford to? Have you ever seen an elderly person, frail and bed-ridden with disease die because they couldn't afford the care they needed? Have you ever been to a homeless shelter and fed the sick and the poor? Have you ever seen someone eaten up with AIDS? A single mother trying to make ends meet on the minimum wage, her children eating only beans and rice? How much further are you going to reduce programs for the poorest of the poor? Do you think that we are really created equal and have the same opportunities? Do you think someone born with brain damage is any different than someone who develops a mental illness? Do you think I had a choice to be born with a mental illness called Dysthmia? Do you think that someone else born with a debiliatating disease is going to be afforded the same opportunities as yourself? Do you think that you can continue to make cuts in social programs and people really deserve less? Do you think that Jesus would have wanted you to make these kind of sacrifices? Where is your heart? How can you deny money for social programs and give yourself a raise? How can you justify allowing the poorest of the poor to live any less than they are already living? How can they change their lives for the better when their own government neglects the responsibility to insure that the public health and the public welfare? Have you no decent sense of morality or do you think that the poor are poor because they had a choice? Who would choose to be poor? Who would choose to have a mental illness? Who would choose to slowly die from a disease they had no choice to have? Who is going to slowly die from the choices that you make? Will you be responsible for your decision? What will you tell the Creator when your time comes that you made a decision to cut social programs and increase the suffering of the sick and the disabled? Do you not think that your decisions have any impact on your future? Do you think that because you are in the position you are in that you have a greater responsibility to the majority or should you speak for the minority of the poor people who already have nothing? How are you going to feel some day when you realize on your dying day that you are going to have to account for your actions, neglect, and human suffering? I implore you to consider the impact that these cuts will have on the poorest of the poor, I implore you to act in a way that protects the poor from the rich, that stands up for the weak, that provides government programs that support the poor and not force them to die and wither slowly from their disease. I did not ask to be born with Dysthmia, I did not pray for this illness to control my life, I do not want to have to take medication for the rest of my miserable life!! How are cutting these programs going to control the excess of the rich, how are they going to benefit anyone, how are they going to impact people who are desperately trying to make ends meet now? How are you going to deny them treatment from a disabling condition that has left them impoverished and without means of making it on their own in this world? This is reprehensible -- our public health care is a national disgrace in this country, you have the power to change this, you have the power to stand up for the poor, you have the power to make a difference.

Submitter : Mr. Keith Nelson **Date:** 08/16/2006

Organization : Northwest Human Services

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

A 14 percent reimbursement cut will for clinical social workers providing services for Medicare clients will harm the ability to provide already scarce services in community health centers such as the one in which I work, already hard-hit by cuts. The clients already are not being seen due to excessive demand, and so then seek expensive services in hospitals and Emergency Rooms at much greater expense to Medicare. In our mental health clinic, this will be, not incidentally, due to a short of psychiatrists, extremely problematic in cutting a lower cost yet effective means of addressing the needs of clients that, if not properly addressed, increase overall health care costs.
This is a very short-sighted move; clinical social workers are preferring to work in private settings. In rural areas, there are very few practitioners of any sort, and this will cause even more providers to avoid these areas. Please, do not reduce work values for clinical social workers effective January 1, 2007.
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 "bottom up" formula to calculate practice expense. Select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Sincerely,
Keith R. Nelson, LCSW
Salem, OR

File code CMS-1512-PN.

Submitter : **Dr. Jon Bellantoni** **Date: 08/16/2006**

Organization : **Susquehann Ob-Gyn**

Category : **Physician**

Issue Areas/Comments

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

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

Please see attached file letter

CMS-1512-PN-1533-Attach-1.DOC

Attach
#1533

Susquehanna Obstetrics, Gynecology and Nurse Midwifery

Dear Dr. McClellan:

I am an gynecologist practicing in northern Maryland.

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

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

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

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

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

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

Importantly, it appears that some of the assumptions used to recalculate the Medicare Physician Fee Schedule were inaccurate. For example, CMS calculated the equipment cost at less than half of what it should be, because they based it on older pencil beam

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

As a gynecologic practice, our group has more access than perhaps any other specialty to those who are at the most risk of osteoporosis. Over eight years ago, we undertook bone densitometry testing to provide point of service care. We developed internal expertise and qualifications to diagnose and treat osteoporosis when high quality scanning was not available in our community. Even today we are able to provide superior interpretation and internal quality control of our scanning that we do not see evident in large radiology practices. Our understanding of the disease process and the limits of BMD testing make us highly effective users and not abusers of this technology. The proposed reductions in reimbursement will make it impossible for us to continue to run our high quality office program.

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

Thank you.

Jon J. Bellantoni, M.D.
President
Susquehanna Obstetrics and Gynecology, P.A.

Submitter : Dr. Gregory Moffitt **Date:** 08/16/2006

Organization : ECET

Category : Physician

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

Please reconsider your position on the reimbursement cuts regarding DXA scans. It appears that some of the data used to formulate these cuts were flawed. Specifically, the operating and utilization costs were based on pencil-beam technology, whereas most systems today have fan beam technology. These cuts will make in-office DXA cost prohibitive and reduce access to this valuable service. Thanks, Greg Moffitt

CMS-1512-PN-1535

Submitter : **Dr. Benjamin Anderson** **Date: 08/16/2006**

Organization : **American Society of Breast Disease**

Category : **Health Care Professional or Association**

Issue Areas/Comments

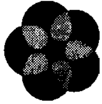
Other Issues

Other Issues

On behalf of the 1,200 members of the American Society of Breast Disease, the nation's largest multidisciplinary membership of healthcare professionals dedicated to the fight against breast disease, we comment on the changes in coded values for total mastectomy versus partial mastectomy masked the actual difficulty for surgeons in performing partial mastectomy (also known as lumpectomy), which is the less invasive surgical procedure.

CMS-1512-PN-1535-Attach-1.DOC

HF-1 [illegible]
#1535



American Society of Breast Disease

August 3, 2006

The Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1512-PN
PO Box 8017
Baltimore, MD 21244–8017

Dear Dr. McClellan:

On behalf of the American Society of Breast Disease Board of Directors and the Society's 1,200 breast healthcare professionals, I write to address practice concerns raised by the proposed changes in RVUs for CPT codes 19160 and 19180. The Society recommends a delay in the implementation of the practice expense proposals scheduled for January 2007 implementation until enough data and information are provided to allow adequate review and assessment of the validity of the new methodology.

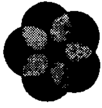
The American Society of Breast Disease represents the full spectrum of healthcare professionals (medical oncologists, pathologists, radiation oncologists, radiologists, surgeons, breast cancer nurses, advocates, and administrators) engaged in the fight against breast disease. This letter reflects the interdisciplinary concerns of the Society's Board of Directors and the membership it represents.

The proposed changes listed on page 290 in CMS-1512-PN include an increase in physician work RVUs for code 19180 (removal of breast – total) from 8.79 to 15.61. At the same time, RVUs for code 19160 (partial mastectomy) remain unchanged at 5.98. It appears as though the RVUs for these two procedures may have been treated individually in the revaluation process. We believe these surgical options for treatment of breast cancer need to be considered together and during the same coding revision period.

We applaud the recognition that total mastectomy has been undervalued. We agree that the increase for code 19180 is most appropriate, and puts its valuation more in line with other oncologically therapeutic surgical procedures such as bowel resections, which have physician work RVUs ranging from 13.92 to 35.08 (codes 44110 to 44146). In the prior scheme, mastectomy was valued at a similar level to that of placing a tunneled port-a-cath (code 36561, 5.99 RVUs), despite the fact that the latter procedure is much simpler and less time consuming to perform.

However, we believe that the partial mastectomy (lumpectomy) code 19160 should be addressed in a fashion similar to that of total mastectomy to avoid a significantly adverse impact on patient treatment for breast cancer. We call your attention to the following.

- American women have benefited greatly from the widespread use of breast conserving surgery, i.e., lumpectomy (CPT 19160).
- There is general agreement in the surgical community that partial mastectomy (lumpectomy) (CPT 19160) is equally challenging for the surgeon as compared to



American Society of Breast Disease

mastectomy (CPT 19180). Breast-conserving surgery (lumpectomy) requires consideration for skin incision design, fibroglandular resection orientation, surgical margin adequacy, and preservation of breast cosmesis.

- In some aspects, a mastectomy can be easier to perform than a lumpectomy simply because the boundaries of dissection are anatomically defined.

- The proposed codes provide nearly equal RVUs for a partial mastectomy with those of breast biopsy (CPT 19120), and indicate an even greater value for a wire localized biopsy (CPT 19125) despite the fact that a partial mastectomy is significantly more difficult to perform correctly, since (1) unambiguously negative margins for cancer must be obtained and (2) breast cosmesis must be preserved despite the more extensive region or segment of tissue being removed. Unlike a diagnostic breast biopsy, the partial mastectomy is a therapeutic procedure that, if done correctly and in conjunction with breast irradiation, provides mortality benefit to women with invasive cancer.

We believe that the proposed new RVU schedule may raise the possibility for some surgeons to perceive a financial incentive to forego breast conservation in favor of mastectomy. The public health result of this RVU disparity may be unnecessarily radical surgeries because mastectomy will be reimbursed at a rate nearly three times higher than breast-conserving surgery.

It is our understanding that unless this issue is addressed immediately, it cannot be revisited until the next 5-year cycle that ends in the year 2011. By that time, potentially thousands of women may have undergone unneeded mastectomies. We, therefore, respectfully suggest that this problem should be addressed immediately and prior to any implementation.

We believe that the discrepancy in RVUs for CPT codes 19160 and 19180 justifies a review by the CMS prior to any change. The American Society of Breast Disease is prepared to provide any supporting information to assist in that review. Thank you for the opportunity to comment on these important issues.

Sincerely,

Benjamin O. Anderson, MD
President, American Society of Breast Disease

cc: Thomas Russell, MD, American College of Surgeons
Helen Pass, MD, American Society of Breast Surgeons
Raphael Pollock, MD, PhD, Society of Surgical Oncology
Gabriel Hortobagyi, MD, American Society for Clinical Oncology
Patrice Tosi, Susan G. Komen Breast Cancer Foundation

Submitter : **Dr. Neil Gladstone** **Date: 08/16/2006**

Organization : **MyObgyn**

Category : **Physlcian**

Issue Areas/Comments

Other Issues

Other Issues

Re imbursement for DXA scanning. At the present time, recognition and rx of osteoporosis is poorly understood and under utilized. The convience to the patient of having DXA units available in provider's offices increases the compliance of the patient. I had this experience with Mammography in the past. as re imbursement declined, the practice discontinues offering this service. We were extremely efficient, the patients appreciated the convience and compliance was greater. At this time 10% of patients fail to keep their apointments for mammography with the radiologist. Also, many patients are displeased with the level of care recieved from the radiology groups. The only reason the Radiologist offer screening mammograms is that as a group they generate more revenue from the follow up studies, ultrasounds and biopsies which the offices like ours did not do. By dropping Medicare rates to ridiculously low levels, the other payers will do the same. This downward spiral will lead to patients at risk not recieving proper diagnosis and follow up for a preventable disease.

Submitter : Mrs. Diane Colonnello **Date:** 08/16/2006

Organization : DianeColonnello,LCSW,PA

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am strongly in opposition to cms1512pn. I do not feel the govt's spending on other programs should be at my expense. I have not been reimbursed fairly for ten plus years and a cut(14%)to soical workers when congressmen get their raises is outrageous!If everyone was cut equally that would be one thing but to be selective-why not cut contracts with private companies too.This cut will impact the quantity and quality of providers of Medicare!Diane Colonnello

Submitter : **Mrs. Diane Halperin** **Date: 08/16/2006**

Organization : **NASW**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS,

I am writing to inform you that a 14% reimbursement cut will affect me as a Licensed Clinical Social Worker. I am in private practice and cannot afford to live with this proposed cut. This request is to not reduce work values by 7% for clinical social workers in 2007. I am requesting that CMS withdraws the proposed increase in evaluation and management and to have the funds to increase reimbursement to Medicare providers. This is also to request that CMS not approve the proposed "Top Down" formula.

Submitter : **Randy Gllooly** **Date: 08/16/2006**

Organization : **Randy Gllooly**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

The proposed 14% cuts to medicare fees will jeopardize the care of these vulnerable people. Licensed social workers will be forced to focus more of their practice on individuals and families who can pay or who have private insurance. By comparision to other professional fields, social workers receive only moderate compensation for the great works that they perform for society. With budget cuts coming to other areas of the caring fields and underemployment and family discord on the rise, it would be unfortunate if our most vulnerable individuals and families did not have the support that they need to put their lives back together.
A licensed clinical social worker must graduate from an accredited master's program, take a licensing exam and in most states work in the field for about 3000 supervised hours before earning their license. Yet they charge relatively moderate fees compared to the professions of psychiatry and medicine who they have largely replaced in recent years as the front line caregiver for those in need. I would respectfully ask that you reconsider the plan to cut medicare funding for social work services. Social workers play an important role in not only helping individuals and families, but also in bringing together communities in order to make our country great.

Submitter : **Dr. Kirk Bradley** **Date: 08/16/2006**

Organization : **Body Dynamics Physical Therapy Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached letter 1 page in length.
Thank you

CMS-1512-PN-1540-Attach-1.DOC

H/HA_h
#1540

Body Dynamics Physical Therapy Inc.
2105 West March Lane Suite 3
Stockton, CA 95207
Ph (209) 951-3265
Fax (209) 951-3285
e-mail kirk@bdpti.com

8/8/06

CMS Administrator,

I will begin by apologizing for my direct language. But the situation in my opinion has reached a point where the challenges that confront physical therapists must be presented as they are. I am a private practice physical therapist and have been the owner of Body Dynamics in Stockton, CA for 8 years. I have struggled with "making ends meet" since I have opened and continue to be more challenged as each year passes. In spite of this challenge I have remained open to provide therapy. It is the challenge to provide quality therapy services to my patients for which Medicare revenue accounts for approximately 35%,that I write to you. It has come to my attention that there may/will be yet another impediment for me to overcome to remain capable of providing services. I am of course referring to the June 29th proposed revision in RVU's for the Medicare physician fee schedule. Although I cannot comment on the impact for physicians from this reduction in fees, I am keenly aware of those that confront therapists, particularly those in private practice. With exposure to yet another reduction (6%/10% aggregate) in 2007, I have substantial concern over my ability/capability to provide services in the future. Costs continue to rise, and reimbursement continues to decline. Suffering previous reductions from other 3rd party payers due to "competitive price reductions" through larger insurance contracts, I was forced to consider closing last year. I failed to do so because of strong community support, but am barely making ends meet. My W2 earnings will reflect this!!!

If this sounds like an exaggerated claim or manipulative tactic on my (our) part, I urge you to look deeply into the pockets of myself and other private practice providers. We have no fat!! The complaint about eminent doom seems almost cliché at this time. But the decline in PT providers within the State of California and the overwhelming needs for more therapists cannot be ignored. There is little money in therapy any longer especially considering the costs of preparation to become a therapist. The costs of operations vs. reimbursement provide little incentive to become or remain therapists.

Is the profit margin for my services such that we cannot only ignore the yearly inflation rate but reduce our reimbursement? We have no mechanism to adjust rates on the open market to account for increasing costs in part attributed to energy costs. These are real costs to us like any other business. Would it be unrealistic to have the luxury of an increase in reimbursement as a salient response to increased costs of attempting to care for medically fragile humans? My rates are comparable or less than the mechanic who worked on my vehicle last week. Unfortunately, it appears that this will not happen any time soon. In light of this, please don't reduce the rates!!

So I end this document with a pragmatic and what I would consider quintessential question related to values. Do you consider physical therapy a valued service? If the answer is in the affirmative, than I would strongly ask that you reconsider any actions that reduces reimbursement for outpatient physical therapy services. I am told that changing to RVU's over a 4 year period would assist in this endeavor. Permit us the "luxury" of at least not galloping backwards in our ability to remain a solvent business! We have already made many operational cost reductions in order to remain viable and profitable providers for all patients including the Medicare population. Help us, please!

Sincerely and respectfully,
Kirk Bradley, PT, DPT, M.S., ATC
President, Body Dynamics Physical Therapy, Inc.

Submitter : Dr. Kirk Bradley **Date:** 08/16/2006

Organization : Body Dynamics Physical Therapy Inc.

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

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Sincerely and respectfully,
Kirk Bradley, PT, DPT, M.S., ATC
President, Body Dynamics Physical Therapy, Inc.

Submitter : **Mark VanMeter** **Date: 08/16/2006**

Organization : **Columbus Obstetricians - Gynecologists, Inc.**

Category : **Physician**

Issue Areas/Comments

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

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

This is in reguards to CPT 76075, Dexa Bone Density. It is my understanding that the proposed changes will decrease reimbursement to approximately $38 for this CPT. As a group of OB-GYN's, we are very concerned with this proposal.

Osteoporosis has a very high morbidity and mortality rates associated with it. It can be diagnosed and treated to greatly reduce these factors. However, at this reimbursement, we would not be able to continue providing this service, which would certainly be detrimental to our patients. We believe that this diagnostic procedure should remain a finacially viable tools for physicians to offer thier patients.

Submitter : **Ms. Nancy Freeman RT(R)(M)(BD)** **Date: 08/16/2006**

Organization : **ISCD**

Category : **Other Technician**

Issue Areas/Comments

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

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

Dear Dr. McClellan:

I am Nancy Freeman , a practicing Chief Radiologic Technologist of Mammography and Bone Densitometry for an radiology corporation with four out- patient radiology centers.

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

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

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

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

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

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

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

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

Thank you,

Nancy Freeman R.T.(R)(M)(BD)
Midtown Imaging LLC
West Palm Beach, Florida 33417

Submitter : **Dr. Kirk Bradley** **Date: 08/16/2006**

Organization : **Body Dynamics Physical Therapy Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Body Dynamics Physical Therapy Inc.
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8/8/06

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Sincerely and respectfully,
Kirk Bradley, PT, DPT, M.S., ATC
President, Body Dynamics Physical Therapy, Inc.

Submitter : Dr. Michele Bellantoni

Date: 08/16/2006

Organization : Johns Hopkins University School of Medicine

Category : Physician

Issue Areas/Comments

Background

Background

Technical skill is required to provide an accurate assessment of bone density. As a Hopkins specialist, I frequently am referred patients because a DEXA scan was not performed properly and the care plan for the patient was unclear to the primary care physician. Reducing the reimbursement will result in inadequately trained technicians who will provide inadequate testing.

Submitter : **Mr. David Ravnikar** **Date: 08/16/2006**

Organization : **Mr. David Ravnikar**

Category : **Physical Therapist**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

Dear Dr. McClellan and associates,

I'd like to bring to your attention a serious matter with implications affecting the state of healthcare in America.

As a fellow clinician, I am wholly concerned about the proposed changes in the RVU/physician fee schedule and the negative impact this change will have on patient care. I am sure you are well aware of the current proposal which mandates 2% and 4% consecutive yearly decreases in reimbursement for PT services. Coupled with 2007 PFS conversion factor changes, these cuts will result in a compound decrease in payment for PT services rendered.

I fully understand the need for budget neutrality, however severe cuts such as these will place financial burden on Physical Therapists and could profoundly affect delivery of patient care. Minimally, the cuts could interrupt patient care at some clinics and could result in the sickest of patients encountering difficulty receiving the care necessary for reasons that should be irrelevant.

Additionally, Physical Therapy is not a considerable part of the Medicare expense problem. Disciplines such as Internal Med, Cardiology, FP, and Radiology display Medicare allowed charges four-to-five fold those of PT.

Also, services billed under E/M codes (evaluation and management) make up a substantial portion of funds dispersed by Medicare. Physical therapy billing codes (CPT 97000 series) are NOT part of the E/M codes. Therefore, PT providers should not see resultant cuts in reimbursement of services by Medicare.

Myself and many fellow PTs propose that the Medicare RVU change schedule occur more gradually, perhaps over a period of 6-8 years. In addition, changes in payment to particular services need to reflect those service areas most in need of reimbursement reform.

I thank you for your time.

Submitter : **Barbara McAnally** **Date: 08/16/2006**

Organization : **Huntsville Internal Medicine associates, Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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 : **Christy Latiolais** **Date: 08/16/2006**

Organization : **Folsom Medical Group**

Category : **Other Health Care Provider**

Issue Areas/Comments

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

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

I beleive by changing the reimbursement for DXA scans, many Drs. will not be able to afford to perform these scans and therefore many women will go undiagnosed. Osteoporosis is a serious disease and many women will suffer from fractures if undiagnosed. This will lead to higher hospital and Dr. bills. So, I think the fee schedule should remain the same to prevent further increased costs in other areas.

Submitter : **Dava Weinstein** **Date: 08/16/2006**

Organization : **Dava Weinstein**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Reducing Clinical Social Work fkees for mental health services based on reductyion of physician fees will be a disaster. Social workers provide the bulk of mental health services throughout the country...this will decimate earnings for those committed to serving persons with disabilities and elders.

Submitter : **Dr. barbara cudney** **Date: 08/16/2006**

Organization : **Pratt Internal Medicine Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Regarding: medicare proposed changes to 80% reduction in technical portion and 50% professional component for DXA of axial skeleton)CPT76075). This represents a serious underestimation of the actual costs of providing state of the art osteoporosis screening.

This change is ill advised and I strongly believe will have negative inpact on women's health access to this important test.

Submitter : Dr.

Date: 08/16/2006

Organization : Department of Anesthesiology, University of Iowa

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

At this time when the aging of baby boomers will increase the absolute and relative numbers of Medicare patients, it is quite incomprehensible why CMS is proposing cuts in payments to Anesthesiologists. It would only exarcerbate the growing shortage of qualified anesthesiologists.
As CMS is well aware, it has for a long time undervalued anesthesia work for no good reason, treating the specialty quite differently from others. It is quite pitiful what anesthesiolgists get paid for caring for Medicare patients who are often the sickest and most difficult owing to their multiple comorbidities.
Yet anesthesiolgists have provided this care and indeed advanced the specialty to a point such that complex procedures are now routine in this group of patients; Patients who not quite a decade or two ago would be turned away on account of their severe illnesses.
It is not by chance that Anesthesiologists are now held up as role models for the rest of Medicine in advancing patient care and safety. Where then is the incentive to continually improve care and outcomes if our reward is continued cuts in our reimbursement.
In light of the foregoing, what should be done?
First, CMS should reverse its proposed cuts, and update the anesthesia practice expenses it uses for its 5-year review. The current figures are outdated and CMS should join AMA and ASA in conducting a comprehensive survey to update these data.
Second and in any case, it is past time for CMS to end its longstanding, unfair and discriminatory Teaching Rule as applied to anesthesiologists. There is no good reason for treating the specialty differently from others, including the surgeons with whom we most closely work. Cutting the already pitiful sums CMS pays for concurrent supervision of residents makes no sense especially since other specialities are fully reimbursed in similar situations: This just forces academic practice groups to practice inefficiently by avoiding concurrency and so further worsens the shortage of anesthesiologists and reducing training opportunities. What is the sense or logic in such irrational policies?
Finally, CMS really ought to respond when Congress issues unfunded mandates by pointing out that they are unworkable. Why accept them and then trigger a yearly round of comments and lobbying to ultimately reverse the deicision. It is wasteful and only serves to divert scarce resources. If we as a society demand healthcare in a certain shape and form, then we ought to be told upfront what it costs and be ready to pay for it or not have it. Rather than this annual rigmarole.
We, in anesthesiolgy find this all the more galling since CMS has repeatedly denied us fair reimbursement and now is threatening to cut the current meagre payments again to increase pay for other speciliaties. Where is the fairness in that?

Submitter : **Mrs. Kelly Bordman** **Date: 08/16/2006**

Organization : **Jewish Family**

Category : **Individual**

Issue Areas/Comments

Other Issues

Other Issues

Reducing the fees given to Licensed Social Workers will in turn cause many agencies that serve low-income individuals to either stop serving those populations (Medicare included) or to cause practices to go out of business. In addition, LCSW's could begin leaving businesses to find empolyment in locations that take insurance other than medicare, again causing a shortage or service providers. This is just a bad idea.

Submitter : Dr. Steve Saunders **Date:** 08/16/2006

Organization : Dr. Steve Saunders

Category : Physician

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

Dear Sir/Madame;
I believe that the proposed changes are a necessary beginning to setting the groundwork for continued quality primary care.The facts are well known in the medical community,congress and CMS as far as the economic,technologic and patient care issues that lie ahead if nothing is done.
Therefore,follow through on these changes and help begin to restore our hope that primary care is still relevant and viable or do nothing and contribute to its continued demise.

Thank You.

Submitter : Kimm Cynkar

Date: 08/16/2006

Organization : Kimm Cynkar

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern:

I am a clinical social worker whose practice includes about 50% medicare and medicaid participants. A 14 percent reimbursement cut as is suggested on file code CMS - 1512 would greatly impact my abilty to provide these services. In my area there are few providers who provide mental health services to those who are medicare/medicaid recipients. This cut would likely discourage those of us who do provide these services to continue and would, in my opinion, discourage new practioners in the field to work with this population.
I am requesting that CMS not reduce work values by 7 % for clinical social workers effective January 1, 2007. I am also requesting that CMS withdraw the proposed increase in evaluation and management
codes until they have the funds to increase reimbursement for all Medicare providers.
Finally I request that CMS not approve the proposed Top down formula to calculate practice expense.

Thank you for your time,
Kimm Cynkar LISW

Submitter : Mr. Martin J. Lowery **Date:** 08/16/2006

Organization : New York State Society for Clinical Social Work

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I ask the following:
- don't reduce reimbursement for CSW.
- withdraw proposed increase in evaluation and management codes
- do not approve proposed "bottom up" formula to calculate practice expense because it negatively impacts CSWs.

Submitter : **Dr. Jeffrey Johnson** **Date: 08/16/2006**

Organization : **Central Utah Clinic**

Category : **Physician**

Issue Areas/Comments

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

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

See Attachment

CMS-1512-PN-1556-Attach-1.DOC

Dear Dr. McClellan:

I am an internist practicing in Provo, Utah. I have a special interest in osteoporosis.

The proposal to drastically cut payment for dual energy X-ray absorptiometry (DXA; CPT code 76075) and vertebral fracture assessment (VFA; CPT code 76077) has caused me great alarm. These cuts have been proposed as part of a new five-year review of the Medicare Physician Fee Schedule.

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

The proposed cuts will severely limit the availability of bone density measurement and therefore limit our ability to find, treat, and prevent osteoporosis.

The proposed cuts for DXA and VFA testing for patients with suspected osteoporosis fly in the face of several recent federal directives aimed at improving bone health. Multiple initiatives at the Federal level including the Bone Mass Measurement Act, the US Preventive Services Task Force recommendations, the Surgeon General's Report on Osteoporosis, as well as your recent "Welcome to Medicare" letter, all highlight the importance of osteoporosis recognition using DXA, and the value of appropriate prevention and treatment to reduce the personal and societal cost of this disease. HEDIS guidelines and the recent NCQA recommendations also underscore the value of osteoporosis diagnosis and treatment in patients at high risk.

The ability to have easily available bone density testing along with numberous treatments for osteoporosis have enabled us to improve bone health, reduce numbers of osteoporotic fractures and in the long run save money for patients and the Medicare program.

Contrary to the results seen from much more expensive imaging modalities, DXA and VFA have shown to be effective as part of a diagnosis, prevention, and treatment program that significantly reduces morbidity, mortality and costs.

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

the instrument. This is especially true when performing follow up scans on patients. I personally have taken the time and expense to become trained and certified in reading DXA scans.

In my practice we provide bone density testing for a good percentage of the patients in Utah County. We have many patients in whom low bone density has been found by DXA scan prior to fractures or symptoms developing. By treating these patients we have been able to significantly reduce their risk for fractures and the pain and mortality that goes along with them.

I strongly urge you to not go forward with the proposed cuts in reimbursement for these important technologies used to screen people at risk for osteoporotic fracture. Here is a case where there is clearly a disease that can be detected early and treated successfully. By doing so we can prevent pain and suffering as well as improve quality of life and reduce the cost of caring for the victims of osteoporotic fractures. Please don't undermine our ability to do this by cutting reimbursement for these procedures.

Thank you,

Jeffrey W. Johnson, M.D.
1055 N. 500 W.
Provo, UT 84604

Submitter : **Ms. Sharon Bowland** **Date: 08/16/2006**

Organization : **Washington University Brown School of Social Work**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

As you are aware, social workers provide a majority of mental health care, especially for disadvantaged communities in this country. I have been a private practitioner for 25 years and typically have served 2-3 clients at any given time who are covered by Medicare. Often this is the only reimbursement I receive due to clients' inability to pay the portion not covered by Medicare. The proposed 14% reimbursement cut will mean that I will be less able to provide services for those who are eligible for their mental health care. I am writing to request that CMS not reduce work values by 7 % for clinical social workers effective January 1, 2007. Furthermore, I request CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers. I think CMS should not approve the proposed Top down formula to calculate practice expense. I recommend that they select a formula that does not create a negative impact for mental health providers. While I do not need to make a six figure income, I do need to make an adequate living. While I am committed to serving low income clients, I cannot continue to see Medicare recipients, many of whom have fixed incomes and who are unable to pay out of their pockets for services.

Practice Expense

Practice Expense

As you are aware, social workers provide a majority of mental health care, especially for disadvantaged communities in this country. I have been a private practitioner for 25 years and typically have served 2-3 clients at any given time who are covered by Medicare. Often this is the only reimbursement I receive due to clients' inability to pay the portion not covered by Medicare. The proposed 14% reimbursement cut will mean that I will be less able to provide services for those who are eligible for their mental health care. I am writing to request that CMS not reduce work values by 7 % for clinical social workers effective January 1, 2007. Furthermore, I request CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers. I think CMS should not approve the proposed Top down formula to calculate practice expense. I recommend that they select a formula that does not create a negative impact for mental health providers. While I do not need to make a six figure income, I do need to make an adequate living. While I am committed to serving low income clients, I cannot continue to see Medicare recipients, many of whom have fixed incomes and who are unable to pay out of their pockets for services.

Submitter : **Ms. Carol Phelan** **Date: 08/16/2006**

Organization : **Ms. Carol Phelan**

Category : **Social Worker**

Issue Areas/Comments

Discussion of Comments-
Evaluation and Management
Services

Discussion of Comments- Evaluation and Management Services

I am writing to you to ask that CMS reconsider reimbursement cuts and not reduce work values for clinical social workers effective January 1, 2007. In addition, please do not approve the proposed bottom up formula to calculate practice expenses and consider selecting a formula that does not create a negative impact for clinical social workers.

Furthermore, I request that CMS withdraw the proposed increase in evaluation and management codes until you have funds to increase reimbursement for all Medicare providers.

Submitter : **Mrs. Shelley Morris** **Date: 08/16/2006**

Organization : **Shelley Morris, LCSW**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:

RE: CMS-1512-PN

I am writing to request the Centers for Medicare and Medicaid Services not reduce reimbursement to mental health providers. With the reimbursement cuts from January 1, 2006, my practice has declined significantly due to paying overhead and the increase in costs due to gas prices. Also, since Medicare is the "standard" other third party payors use to set reimbursement, once Medicare cuts reimbursement other payors soon follow. I request CMS not reduce work values by 7% effective January 1, 2007; withdraw the proposed increase in evaluation and management codes until they have funds to increase reimbursement for all Medicare providers, and not approve the "top down" formula to calculate practice expense.

Sincerely,

Shelley Morris

CMS-1512-PN-1559-Attach-1.RTF

CMS-1512-PN-1559-Attach-2.RTF

Attach# 1559

Shelley Morris, LCSW

Licensed Clinical Social Worker

150 Redstone Avenue Suite A
Crestview, Fl. 32539

Phone: 850-689-8004
Fax: 850-689-8068

August 17, 2006

To Whom It May Concern:

RE: CMS-1512-PN

I am writing to request the Centers for Medicare and Medicaid Services not reduce reimbursement to mental health providers. With the reimbursement cuts from January 1, 2006, my practice has declined significantly due to paying overhead and the increase in costs due to gas prices. Also, since Medicare is the "standard" other third party payors use to set reimbursement, once Medicare cuts reimbursement other payors soon follow. I request CMS not reduce work values by 7% effective January 1, 2007; withdraw the proposed increase in evaluation and management codes until they have funds to increase reimbursement for all Medicare providers, and not approve the "top down" formula to calculate practice expense.

Sincerely,

Shelley Morris, LCSW

Submitter : **Mr. Jeffrey Franz** **Date: 08/16/2006**

Organization : **General Electric**

Category : **Device Industry**

Issue Areas/Comments

Practice Expense

Practice Expense

Dear Dr. McClellan:

I am a scientist practicing in bone health.

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

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

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

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

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

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

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

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

Thank you,

Jeffrey R. Franz
General Electric Company

Submitter : **Mrs. Vicky Glass** **Date: 08/16/2006**

Organization : **National Association of Social Workers**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

Many social workers do not accept Medicare now, due to the lower fee compared to some insurances and the additional paperwork and differenct coding requirements. Also, it has been my experience that Medicare clients often have multiple problems and require additional time and effort to treat. Therefore, Medicare clients already have fewer providers to chose from and this problem will probably be amplified by the additional proposed cuts. The implied message is that the Medicare clients don't deserve the same services as the general population, because many are retired and disabled and not producing income for our society. Another implied message is that the services of the providers who work with these populations are not as valuable as those of medical doctors. The reality is that social workers often have more contact with these clients than medical doctors and that these clients often need on-going support in order to improve the quality of their lives and prevent more in-patient care. It has been my experience that you pay now for preventive and supportive services or you might pay more later for in-patient care. These proposed cuts are an outrage and an insult to Medicare patients, but also to the social work profession, whose members are often underpaid already.

Submitter : **Ms. Sue Rinehart-Schulz** **Date: 08/16/2006**

Organization : **Ms. Sue Rinehart-Schulz**

Category : **Radiologist**

Issue Areas/Comments

GENERAL

GENERAL

I am a radiology Technologist and I am also certified in Bone Density.
To cut the cost of Bone density exams is not cost effect. It cost much more to pay to have hip replacements or to have some have fracture in their spine.
Although with osteoporious any bone can break at any time it usually affects the hip and spine. With the exam the doctors can see where the weakness is and start medication before it goes into a sever break which calls for surgery or a replacement.
The quality of life does go down once there is a severe break or a replacement and death follows some within a year for the older generation.
I believe anyone 30 and above should have the exams and younger if they do not have a balanced diet, have children at a young age, or use any kind of abusive substance whether legal prescribed or illegally gotten.
Keeping the skelton strong helps reduce other ailments.
I just wanted you to understand my position on the use and need of bone density exams.
I also do radiology so bone density is not my only job I do.

Thank you for your time,

Sue Rinehart-Schulz R (RT) CDT

Submitter : **Dr. Daniel Ghiyam** **Date: 08/16/2006**

Organization : **Dr. Daniel Ghiyam**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

re: CMS-1512-PN
DXA scanning is a very important part of patients healthcare management. Without it, doctors will not be able to determine if a patient has osteoporosis or has the signs of getting osteoporosis. Early detection and treatment will benefit the patient and also keep future medical expenses down for the patient. Osteoporosis meds are very expensive for the patient. Like I stated previously, early detection is the key for good healthcare management.

Submitter : Dr. Calin Pop

Date: 08/16/2006

Organization : Dr. Calin Pop

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

RE: PE ON 93701-TC. THIS RVU VALUE OF 0.65 (NOW REVISED DOWNWARD TO 0.64) DOES NOT ADDRESS THE ACTUAL REAL COSTS OF EQUIPMENT OR USE AN APPROPRIATE UTILIZATION ASSUMPTION. WHEN IS THE LAST TIME THE RUC REVIEWED THIS CODE? THEY NEED TO UNDERSTAND THAT THE LATEST DEVICE FROM CARDIODYNAMICS (BIOZ DX) IS $43,995, PLUS TAX AND SHIPPING AND INTEREST OVER THE LEASE. THE COVERAGE FOR THIS CODE IS ONLY FOR CONGESTIVE HEART FAILURE, WHICH MAKES IT HARD TO USE MORE THAN 2 OR 3 TIMES PER DAY. THAT IS A MAX OF 1 HOUR IN AN 8 HOUR DAY. PLEASE CONSIDER THESE COMMENTS AND CHANGE THE INPUTS INCLUDING EQUIPMENT COST AND UTILIZATION RATE.

Submitter : Mr. David Ukoha

Date: 08/16/2006

Organization : Mr. David Ukoha

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I proposed removing the BNF from your PE calculations because they completely destroy the bottoms up idea of your new way of calculating RVUs. If RVUs are based on actual costs, then don t randomly reduce them because you want to spend less money! By definition this pays physicians back LESS than what it costs to do the test. The idea of bottoms up is appropriate only if there is no BNF. Thank you.

Submitter : **Dr. Carlton Pittard** **Date: 08/16/2006**

Organization : **Dr. Carlton Pittard**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Of the 3 inputs used for direct expenses for CPT code 93701-TC, your clinical time and cost are OK but your consumables cost is low (it is $9.96 vs. what should be $12) and the equipment cost is low ($28K vs. what should be at least $39K). These would add to several more dollars per test, sorely needed to keep more of the code s current value. Please make the necessary alterations. Also, lease % amounts are greater than 11% if you haven t checked lately, this should also be revised.

Submitter : **Dr. Catherine Peimann** **Date: 08/16/2006**

Organization : **Southeast Medical Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my concern regarding a decrease in the reimbursement for bone density scanning (DEXA) for screening and treatment monitoring of osteoporosis. I believe that the severe cuts proposed will significantly limit women's access to this service and negatively impact womens health. Please reconsider this proposed cut and/or the amount. I myself provide this service in my office but would have to reconsider offereing it if these cuts are put into effect. In the long term this will only increase costs related to the disease and its sequelae (hip fractures, etc).

Submitter : **Jack Werle** **Date: 08/16/2006**

Organization : **Jack Werle MS, PT**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

It is my understanding that cuts for Physical Therapy (PT) reimbursement of 6% are expected due to changes in RVU. These changes appear to be based on physician desire for 37% more reimbursement for evaluation codes. This reflects the fact that they spend more one on one time performing intermediate complexity evaluations. Under budget neutrality, reimbursement for treatment codes for Physical Therapy codes will be reduced. This, along with other cuts, results in a nearly 10% decrease in reimbursement to Physical Therapists.

This cannot reflect gneuine relative work values. Most physicians spend very little one on one time with the patient, other than with an initial examination, because they can bill for support nursing staff time for chart reviews, data collection, etc and support staff (often on the job trained) to perform "treatments" without the physician even being in the room.

As a PT, I can only bill my personal time. PTs typically spend extensive time with patients performing far more specialized evaluations than the vast majority of physicians are capable of. Treatment is performed by skilled PTs with a masters degree, or licensed PT Assistants (PTA)with associate degrees.

How can our services possibly have less value than that of physicians? We are better trained and more capable to do what we do than physicians are. Futhermore, as a Physical Therapist in private practice, I cannot bill for PTA services unless I'm on site. (That same PTA, under my supervision, doesn't require on-site supervision if I'm providing services under contract to a nursing home, hospital, or CORF. Does that make sense?). Consequently, when I see a patient in the home or at a senior center, I'm billing only for my time, time valued by 21 years experience, a Master's degree, 70 continuing education courses, and specialist certification in Work Capacity Evaluation. After I take away travel expenses, health insurance, liability, and other expenses as a self employed person, the 10% reduction resulting from RVU and other cuts, removes the vast majority of my profit margin (based on comparison to reimbursement working for an employer).

The proposed increases in work expense values will not offset the cuts. In fact, my reimbursement will face a net cut until 2010, when my reimbursement will go up only 2%.

The capitated systems of reimbursement instituted in the 1990's have already limited what we can make. Yet, the demand for therapy services is increasing and will only continue to increase with the aging of baby boomers. If we are to meet our societal committment to our elders, then these cut cannot go into effect. You will remove incentive for therapists to be entrepreneurs, and reduce the attractivity of the profession to young people. Why go into a field that will only see a downward trend in reimbursement?

By the way, we're comfortably middle class, but not rich. I can make about $55000/year as an employee with a mediocre benefits package(compared to six figure incomes for even the lowest paid physicians, or $45000/year for a Honda factory worker, who receives far better benefits than most PTs do). Self employed, I make anywhere from $55000 to $85000/yr after expenses, depending on how good the year is. My malpractice rates have jumped 500% in the last year. Gas has increased 100%. Health insurance has gone up 30% (with a high deductible). If I worked for an employer, his expenses would be going up the same way.

I think current reimbursement is minimally fair, given our skill level and what we do. Again, how are we to attract good talent to our profession, if we face cuts in reimbursement vs. the increasing costs?

Thank you for your attention to my concerns.

CMS-1512-PN-1569

Submitter :

Date: 08/16/2006

Organization :

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Please do not reduce work values by 7 % for clinical social workers effective January 1, 2007. I am also requesting to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers and suggest that CMS not approve the proposed Top down formula to calculate practice expense. Request they select a formula that does not create a negative impact for mental health providers.

Submitter :

Date: 08/16/2006

Organization : **UIHC**

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.

Submitter : **Mr. raul banos** **Date: 08/16/2006**

Organization : **Private Practice**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam,
I just been informed of a proposed notice in the Federal Register dated 6/29/2006 that addressed possible changes in the fee schedule for SWs and medicare physicians. The proposed 14% reimbursement cut is totally unacceptable. As a provider, if these changes are implemented would mean that I would re-consider accepting medicare patients. It appears that payment to physicians' will go up at the expence of social workers compensation for services. I hereby request that CMS not reduce work values for clinical social workers effective 1/1/07. In addition, I'm also requesting that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers. And lastly, I'm also requesting that CMS not to approve "bottom up" formula to calculate practice expense. A formula needs to be created that does not create a negative impact for clinical social workers who have very little practice expense as providers.
Thank you for your attention to this matter.

Sincerely,

Raul Banos L.C.S.W.

Submitter : Mrs. Martha Phelps **Date:** 08/16/2006

Organization : self private practice

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

RE: File code CMS-1512-PN

To Whom It May Concern:

As a social worker in the area of Central Florida I consistently work with populations served through Medicare and Medicaid. As I am sure you are aware this population tends to be a group of individuals who are not always well versed in service delivery and often have a difficult time gaining access to services. It is my understanding that The Centers for Medicare and Medicaid Services (CMS) has released a proposal that would reduce Medicare reimbursement to certain health and mental health providers. These cuts are going to affect not only professional service delivery but also the ability of the consumer to access care. According to the information in the proposal Clinical social workers, clinical psychologists, anesthesiologists, and chiropractors are among those targeted for the most extreme reduction in rates for service delivery.

Specifically, CMS is proposing that clinical social workers receive a 7 percent reduction in work values and a 2 percent reduction in Practice Expense values effective January 1, 2007. An additional proposed 5 percent decrease in Practice Expense values is to occur by 2010. In a consumer driven professional field, I am concerned about the direction this proposal is taking. Already it is difficult for many professional to provide the needed services to this population given the rates currently. As I am sure you are aware the overhead for maintaining a professional practice is often daunting when it comes to surviving with the reimbursement rates. My private practice receives several calls weekly from Medicare recipients seeking treatment. There are few individuals in our area that provide the services for this population. If in fact the rates are reduced as proposed, logical forecasting would demonstrate an even greater deficit for consumer related services to Medicare recipients.

Clearly the proposed cuts are not in the best interest of the Medicare consumer nor the professionals who continue to attempt to provide services at the current rates which are challenging to begin with. I would like to request as a professional social worker that this proposal be reconsidered. A 14% reimbursement cut will most likely preclude my practice from ever accepting Medicare clients. I would like to request that CMS not reduce work values by 7% for social workers. I would like to request that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and I would like to request that CMS not approve the proposed Top down formula to calculate practice expense.

If in fact a revision of the budget needs to be considered, please research a method which does not negatively impact providers, which in turn will impact the consumer.

Sincerely,

Martha M Phelps, LCSW

Practice Expense

Practice Expense

RE: File code CMS-1512-PN

To Whom It May Concern:

As a social worker in the area of Central Florida I consistently work with populations served through Medicare and Medicaid. As I am sure you are aware this population tends to be a group of individuals who are not always well versed in service delivery and often have a difficult time gaining access to services. It is my understanding that The Centers for Medicare and Medicaid Services (CMS) has released a proposal that would reduce Medicare reimbursement to certain health and mental health providers. These cuts are going to affect not only professional service delivery but also the ability of the consumer to access care. According to the information in the proposal Clinical social workers, clinical psychologists, anesthesiologists, and chiropractors are among those targeted for the most extreme reduction in rates for service delivery.

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to request that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and I would like to request that CMS not approve the proposed Top down formula to calculate practice expense.

If in fact a revision of the budget needs to be considered, please research a method which does not negatively impact providers, which in turn will impact the consumer.

Sincerely,

Martha M Phelps, LCSW

Submitter : **Dr. Todd Popp** **Date: 08/16/2006**

Organization : **Critical Care and Pulmonary Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I urge the CMS to finalize the recommended work RVU increases for E/M services. Caring for hospitalized patients has become more complex over recent years. The increasing number of uninsured means patients present later in their disease processes. The increasing number of elderly patients bring far more complex medical issues as well. Time spent coordinating and providing care is not fairly reimbursed currently. I would strongly urge the CMS to reject any effort to lower the improvements in work RVU's for E/M services.

Submitter : **Dr. Amolak Singh**

Date: 08/16/2006

Organization : **University of Missouri**

Category : **Physician**

Issue Areas/Comments

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

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

I strong oppose proposed reductions in RVUs for DEXA and nuclear medicine procedures. You should consider reducing RVUs for those physicians who interpreting these studies with little or no ACGME accredited training specific to this discipline and with no board certification (ABNM). This practice is widespread in US. Reduction in RVUs for those who lack special expertise and will save you lot of money and improve patient care across USA.

Submitter : Dr. Yasmeen Khan

Organization : Dr. Yasmeen Khan

Date: 08/16/2006

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Medicare pay cut to Anesthesiologists:

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

I am writing to condemn such cuts in payments because our speciality will die out fast if such cuts happen. I and many of my collegues will stop practicing anesthesia if the cuts happen or move to a country which pays better. Please stop these medicare cuts.

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.

Yasmeen Khan,MD
4124 Raptor road
Eagan, MN 55122
314-368-7091

Submitter : **Dr. Kurt Slotabec** **Date: 08/16/2006**

Organization : **Manatee Surgical Center**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

see attached

CMS-1512-PN-1576-Attach-1.DOC

AHach#1576

Manatee Surgical Center
601 Manatee Ave. W.
Bradenton, FL 34205

August 16, 2006

Mark McClellan, M.D., PhD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Dear Dr. McClellan,

In the June 29 Federal Register, CMS proposed a new practice expense methodology, as well as changes in work values stemming from the recently conducted Five Year Review. Due to these changes, Medicare payments to Anesthesiologists and Anesthesia personnel would be cut 10% over the next four years. These cuts to anesthesiologists and other specialists are meant to supplement the overhead costs increases for a handful of specialties. Further, these cuts are in addition to the Sustainable Growth Rate (SGR) formula cuts of 4.7% expected January 1, 2007. I am concerned because these cuts are proposed without precedent or justification and would have wide ranging effects on hospitals and patients' access to healthcare.

- These cuts are severe and unprecedented. In 1997, and again in 2002, CMS Part B payment formula changes resulted in adjusted payment work values of less than one percent each. Now, CMS is proposing a 10% cut by 2010.
- Anesthesia is already undervalued by Medicare relative to market rates. While Medicare pays 80% of private market rates for most Part B services, Medicare now pays only 37% for anesthesia services.
- Many services whose reimbursements have been affected by the Five Year Review have been subjected to extensive study and examination. However, it appears no such examination has been made of the effects that a 10% cut in anesthesia reimbursement would have on patients' access to the healthcare system.

The end result of the above actions would place reimbursement for anesthesia services at the same rate as in 1991! The practice of anesthesia has become much safer since 1991 because of advancements in equipment and medications as well as superior training of anesthesia providers. If these cuts are allowed, it will be difficult if not impossible to afford new technologies and pharmacologic advancements. It will be difficult to even sustain our current equipment and overhead expenses. In addition, experienced anesthesia providers and mentors will invariably leave the workforce or take on a greatly reduced role in patient care. This would result in a critical manpower shortage just as our population is getting older and requiring more care. The practice of anesthesiology may even "regress", and become less safe than it is today by having to revert to older technologies and outdated equipment in the hands of less experienced practitioners.

The data that the CMS is using to calculate overhead expenses is outdated and significantly underestimates actual expenses. The CMS should gather new data on anesthesia practice expenses and replace to decade old data it is currently using. The American Society of Anesthesiology (ASA) and AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. This much needed survey should be launched immediately to improve accuracy of practice expense data for all specialties.

For these reasons, I request CMS suspend its proposal of Medicare cuts in anesthesia reimbursement , in order to allow for a comprehensive review of the impacts such cuts would have on anesthesia technology, manpower, and patient safety.

Thank you,

Kurt Slotabec, M.D.
Medical Director
Manatee Surgical Center