Submitter : **Mrs. Janet Isbell** **Date: 08/16/2006**

Organization : **Alternative Options Counseling Services, Inc.**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Cutting the medicaid allowance for clinical social workers would put a hardship on the profession and a hardship on the clients. The cost of our education is astronomical, we serve clients who have the least our pay is nominal, please reconsider the cuts. Everyone will suffer.

Submitter : Mr. Kenneth Gerber **Date:** 08/16/2006

Organization : Mr. Kenneth Gerber

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed cuts in this bill will make it difficult to provide the current level of services available by qualified and experienced social workers in private practice.
Thank you for reviewing these comments.
Kenneth Gerber, LCSW

CMS-1512-PN-1579

Submitter : **Mr. John Hitchens, CRNA** **Date: 08/16/2006**

Organization : **AANA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1579-Attach-1.DOC

HHCCA TF
1579

Dr. Mark McClellan, MD PhD
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Dr. McClellan:

We wish to express our serious concern that the Centers for Medicare & Medicaid Services (CMS) proposed rule making adjustments in Medicare Part B practice expenses and relative work values (71 FR 37170, 6/29/2006) severely cuts Medicare anesthesia payment without precedent or justification. We request the agency reverse these cuts.

The proposed rule mandates 7-8 percent cuts in anesthesiology and nurse anesthetist reimbursement by 2007, and a 10 percent cut by 2010. With these cuts, the Medicare payment for an average anesthesia service would lie far below its level in 1991, adjusting for inflation. The proposed rule does not change specific anesthesia codes or values in any way that justifies such cuts. In fact, during CMS' previous work value review process that concluded as recently as December 2002, the agency adopted a modest increase in anesthesia work values. Further, Medicare today reimburses for anesthesia services at approximately 37 percent of market rates, while most other physician services are reimbursed at about 80 percent of the market level. The Medicare anesthesia cuts would be in addition to CMS' anticipated "sustainable growth rate" formula-driven cuts on all Part B services effective January 1, 2007, unless Congress acts.

Last, hundreds of services whose relative values and practice expenses have been adjusted by the 5-year review proposed rule have been subject to extensive study and examination. However, the proposed rule indicates no such examination has been made on the effects that 10 percent anesthesia reimbursement cuts would have on peoples' access to healthcare services, and on other aspects of the healthcare system.

For these reasons, we request the agency suspend its proposal to impose such cuts in Medicare anesthesia payment, review the potential impacts of its proposal, and recommend a more feasible and less harmful alternative.

John T. Hitchens, CRNA
1715Farmshire Court
Jarrettsville MD 21084

Submitter : **Ms. Anna Ratkus** **Date: 08/16/2006**

Organization : **Aquatic Health**

Category : **Physical Therapist**

Issue Areas/Comments

Practice Expense

Practice Expense

See Attached

CMS-1512-PN-1580-Attach-1.WPD

AHacm#
1580

AQUATIC HEALTH & REHABILITATION SERVICES, INC.
595 N. COURTENAY PKWY #203 | 829 N. ATLANTIC AVENUE
MERRITT ISLAND, FL 32953 | COCOA BEACH, FL 32931
(321) 453-8484 FAX: (321) 453-8448 | (321) 799-8450 FAX: (321) 799-8452

August 15, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U. S. Department of Health and Human Services
Attn; CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Re: Medicare Program: Five-Year Review of Work Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan;

My name is Anna Ratkus, DPT; I am a physical therapist with Aquatic Health and Rehabilitation Services, Inc. in Merritt Island and Cocoa Beach, FL. I am a graduate of the Duke University, and have been practicing PT for 3 years.

The purpose of this letter is to comment on the June 29 proposed notice that set forth proposed revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule.

Over the last several years, reimbursement for physical therapy has been on a steady decline. The proposed cuts would cause many physical therapy facilities to close or diminish the care available to our patients. I strongly urge that CMS ensure that severe Medicare payment cuts for physical therapists and other healthcare professionals do not occur in 2007. Furthermore, I recommend that CMS transition the changes to the work relative value units (RVUs) over a four year period to ensure that patients continue to have access to valuable health care services.

I am making the above recommendations for the following reasons:

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

2) Under current law, the "Sustainable Growth Rate" (SGR) formula is projected to trigger a 4.6% cut in payments in 2007. Similar cuts are forecasted to continue for the foreseeable future, totaling 37% by 2015. The impact of these cuts would be further compounded by a budget neutrality adjuster proposed in the 5-year review rule that would impose cuts on top of the SGR. It is unreasonable to propose policies that pile cuts on top of cuts.

3) CMS emphasizes the importance of increasing payment for E/M services to allow physicians to manage illnesses more effectively and therefore result in better outcomes. Increasing payment for E/M services is important – but the value of services provided by all Medicare providers should be acknowledged under this payment policy. Physical therapists spend a considerable amount of time in face-to-face consultation and treatment with patients, yet their services are being reduced in value.

I would like to take this opportunity to thank you for your time and consideration in this matter.

Sincerely,

Ken Jagdmann, PT

Submitter : **Miss. Tracy Stack** **Date: 08/16/2006**

Organization : **Miss. Tracy Stack**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

Dear CMS:

I am a physical therapist working in Chicago and have been practicing for eight years. My initial degree was a bachelors in physical therapy. In the past five years, I have completed my masters of health science in physical therapy and recently achieved the orthopedic certified specialist offerred through the APTA. My position is that of a clinician and a regional clinical coordinator. This involves direct patient care, clinical mentorship throughout three midwest states, direction of the student program in these states, compliance issues, training in documentation for reimbursement and skilled services, and leadership on clinical issues.

I am writing to comment on the 6/29 proposed notice to revise the work value units. I am firmly against these revisions and do NOT want to see these cuts occur for our patients in physical therapy and in other health care professions. These cuts would significantly limit our patients ability to have access to the care they need to help them return to optimal function and health. I urge you to transition the change in work relative value units over the four year period to allow the greatest access to physical therapy services that our patients deserve.

Sincerely, Tracy H. Stack, PT, MHS, OCS

Submitter : **Ms. CYNTHIA CROSS** **Date: 08/16/2006**

Organization : **ASSOCIATES IN FAMILY HEALTHCARE**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

IT IS EASY TO DISMISS THE ELDERLIES NEEDS. THE TRUTH IS THAT WE SHOULD BE CONCERNED WITH THEIR QUALITY OF LIFE. THE BETTER THEIR LIVES ARE THE LESS THE COST IT IS TO SOCIETY IN THE LONG RUN. WE NEED TO THINK LESS ABOUT RIGHT KNOW AND MORE OF THE LONG TERM IF WE ARE GOING TO HAVE A MEDICARE BENEFITS IN THE FUTURE. SHORT TERM GOALS SHOULD NOT DESTROY THE LONG TERM. IT SHOULD BUILD FOR THE FUTURE. A SOCEITYS WHO TAKES CARE OF THEIR ELDERLY AND YOUNG IS PREPARED FOR THE FUTURE FROM LEARNING FROM THE PAST.

Submitter : **Dr. Jeff Jundt** **Date: 08/16/2006**

Organization : **Arthritis Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Practice expenses continue to increase. Reimbursement continues to decrease. 14+hr days to "break even" as these changes cut deeper are approaching breaking point. I have already quit Medicaid this month, starting to limit new Medicare and shifting to other business endeavors. I can't start expensive EMR systems, won't keep my DEXA machine if further cuts and current unfair reimbursement for infusions continues (we make no profit to cover Biologic infusions but yet spend over $500,000 at risk to break even to offer to patients. I am not asking to be on par with the plumbers and electricians... just fair price for the care we give patients!!!!

IF the cuts continue, I like many of many colleagues are planning other businesses where we will be appreciated and compensated appropriately. Doctors are the only people that can DOCTOR! Don't jeopardize this valuable resource. You to may need our services only to find that your specialist is earning more respect and compensation running his car wash than caring for patients (I know several examples who have already done this)

Sincerely,
Jeff Jundt MD
254-258-6648
Killeen, Tx

Submitter : Dr. Eric Christoff **Date:** 08/16/2006

Organization : Northwestern Memorial Physicians Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

It is important that those of us in primary care fields and who also treat HIV infection be compensated for our time with patients. Nothing we do matters if patients cannot get and safely and without side effects manage their medications and the clinical advice we provide them. The time we spend with patients to address all concerns or as many as we can at any given visit helps to ensure this. Doing tests and procedures on patients and compensating doctors for those generally does NOT do this.

Submitter : **Greg Fritz** **Date: 08/16/2006**

Organization : **Skagit Island Rehab Group**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

As sure as life it's self, any changes in the reduction of fees will spawn the bad guys to just get "badder" more Fraud and more hyperbillings. What are you thinking trying to take moneys away from the legitamate Physical Therapy Practices and Hospitals, Nursing Homes etc...

I appeal for reconcideration on the proposed fee reduction for Out Patient Physical Therapy Services.

Greg Fritz, PT
Anacortes Physical Therapy

Submitter : **Mr. Mark Lanning** **Date: 08/16/2006**

Organization : **University of Washington School of Physical Therap**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Re: Medicare Program; Five-Year Review of Work Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology.

My name is Mark Lanning and I am a third year student in the University of Washington School of Physical Therapy Doctorate of Physical Therapy program (Class of 2007)and a student member of the American Physical Therapy Association. I am writing regarding the proposed June 29 revisions to work relative value units that revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule and to encourage you to oppose Medicare payment cuts to physical therapists in 2007. Rather, I would encourage your support for CMS transitioning of the changes to the work relative value units(RVUs)over a four year period to ensure that patients continue to have access to valuable health care services.

The rationale for opposing the proposals are simple: Cuts are already scheduled for physical therapy billing from Medicare and physical therapy services are already undervalued in comparison to other health care professionals. Physical therapists, with the assistance of other health professions, have spent considerable effort getting direct access in recognition of the increasing quality of physical therapy care. The proposals will adversely affect the ability of millions of people to physical therapy services.

As a student one year from graduation, I see first hand the positive impact that physical therapists have on injured and disabled. A physical therapist spends more time with a patient than a doctor will, but our services are being reduced in value. What result? The result will be that more expensive health care options are going to be the only ones left if physical therapists decided to pursue other professions based on financial decisions. In the long run, the net result will be a more expensive medical system with a greater drain on Medicare/Medicaid resources. Cuts are already in the offing. Supporting even more onerous cuts will result in reducing the number of practioners in an already under-supplied profession.

Please oppose the June 29 proposals.
Mark Lanning, SPT (2007)

Submitter : **Dr. Gitendra Rajiyah** **Date: 08/16/2006**

Organization : **The Heart Center of The Oranges**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Practice Expense

Practice Expense

You really need to change one fundamental assumption that you are using in your practice expense for technical CPt codes that all equipment is used 50% of the time or 75,000 minutes per year. Not even close for some codes, and underestimated for others that are used almost all the time. It needs to be different for each code.

Submitter : **Dr. Ricky Kellenberger**

Organization : **Fort Scott Family Practice**

Date: 08/16/2006

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

This is a case study in how a code amount is horribly out of step with real costs. This is in reference to CPT 93701-TC. The proposed amount for full implemented RVU is 0.64, which includes no physician work. At proposed rates, this equals $23 reimbursement (of which I only get 80% from CMS, but OK let s use $23). So, taking away disposable sensors of $12 per patient, you get $11 left. Taking away the $8 it takes for the tech to do the test, I am left with $3. Now the problem: I recently bought a BioZ device from CardioDynamics and paid $40,000, with interest my equipment lease payment over five years is $900 per month. At $900 per month and $3 per test reimbursement for the equipment, I have to do the test 300 times a month TO BREAK EVEN.

Submitter : **Mrs. Cari Thomason** **Date: 08/16/2006**

Organization : **Internal Medicine Associates of Grand Junction**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1589-Attach-1.DOC

Attachment
1589

Internal Medicine Associates of Grand Junction, PC
744 Horizon Court, Suite 301, Grand Junction, CO 81506
Barry W. Holcomb, MD
Donald E. Maier, MD
Frederic B. Walker, IV, MD
J. Chris Hornsby, MD

August 15, 2006

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

To Whom It May Concern:

During the most recent 5-year review of CPT codes CMS published proposed changes to several codes. One of those codes was 76075 a DXA bone density scan. I would like to express concern over the decrease in reimbursement for this code. If this code continues to decrease at the rate proposed it could hinder future access to DXA scans. The technology to provide this type of service is changing rapidly and will require upgrades if not a completely new machine within the next 5 years.

Internal Medicine Associates of Grand Junction practices Internal Medicine over 60% of our patients are over 65. We try to provide a different level of care for our elderly population so that they do not make multiple trips to different offices to receive lab tests and bone density scans. In 2005 our office purchased a new, fan beam Bone Density scanner with the capability of vertebral assessment. This machine cost our practice $90,000.00. The new technology this machine helps our office to evaluate and diagnosis Osteoporosis faster and more accurately. The costs associated with having a trained and state certified DEXA operator require a reimbursement that will allow us to continue to provide this test to patients. We currently utilize this machine 52% of the time. Each one of these scans requires an interpretation from the physician and establishing of a treatment plan which takes approximately 30 minutes of a physician and staff time.

Please re-evaluate the reduction in work RVU's for this CPT code. The work RVU's need to stay where they are at so that offices can continue to provide cost effect and efficient care to patients.

Sincerely,

Cari Thomason
Practice Manager
Internal Medicine Associates of Grand Junction

Submitter :

Date: 08/16/2006

Organization :

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

With the therapy cap already an arbitrary limit on reimmbursement for therapy services and thus an uneven playing being established between private and hospital practices the fee cut for therapy services is another stab at smaller practices who don't have the luxury of surgical procedures and other high profit centers of hospitals to offset lost revenues that keep the practice door open. Therapists are in high demand, rents are rising along with energy costs and malpractice, we already lose money on every Medicaid patient at 35 cents on the dollar charged, and receive about 50 cents of every dollar on Medicare patients with tons of red tape, so this is another attempt at a nail in the coffin for the small practitioner in my view. The expertise required to deliver high quality care comes at a price and the price is not going down at 6-10% per year while the population ages and service demand rises. This combined with a CMS paranoia that fraud and abuse are rampant in the therapy system and that we need new independent contractors who are paid according to the claims they can retroactively deny show a pattern of cost savings at the expense of front line care of the patient. Change the model so good care is rewarded and efficiency is rewarded and the system would be much further ahead. Be sure CMS knows who is billing therapy codes, eliminate physician owned practices and chiropractic uses of therapy codes. Things would be much clearer if those simple steps were done first. you are looking at the wrong things to contain therapy costs.

Submitter : **Dr. Patricia Stafford** **Date: 08/16/2006**

Organization : **Women's Imaging & Wellness, Inc.**

Category : **Radiologist**

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 : **Date: 08/16/2006**

Organization : **Society of Breast Imaging**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1592-Attach-1.DOC

CMS-1512-PN-1592-Attach-2.TXT

AHGCh-ff
1592

Society of Breast Imaging
1891 Preston White Drive
Reston, VA 20191

Dr. Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATT: CMS-1512-PN
P.O. Box 8014
Baltimore MD 21244-8014
RE: CMS-1512-PN

Dear Dr. McClellan,

Thank you for the opportunity to comment on the recently Proposed Rule changes concerning potential reimbursement downward adjustments for the use of Computer Aided Detection (CAD) and Stereotactic Guidance for percutaneous breast biopsy. The Society of Breast Imaging represents the largest organization in the United States devoted to this specialty. Its members include those who practice in rural and urban areas, academic and community practices.

The Society appreciates the difficult decisions that are involved in reconciling available resources with the federal budget and seeks to work with CMS and other interested parties in achieving the best overall outcome for patients. Several years ago, proposed budget adjustments sought to curtail reimbursement for non-surgical biopsy (such as stereotactic biopsy) and increase reimbursement for surgical biopsy. The current proposal not only continues that approach, but reduces the reimbursement to such an extent that institutions would have a disincentive to perform such biopsies and instead refer patients for surgical excision. Rigorous analysis in the published literature indicates that for properly selected cases, the outcomes are similar for both procedures, but surgical biopsy results in increased resource allocation (including operating room time and nursing assistance) with greater morbidity.

The proposed reduction in reimbursement for Computer Aided Detection (CAD) serves as a disincentive to utilize and further develop this important emerging technology in the quasi-public health effort to which physicians attend with screening mammography. Although computer programs continue to improve, a large number of published studies now indicate a significantly improved performance with the use of CAD. The downstream costs of treating breast cancer which diagnosis has been delayed—notwithstanding the often poorer prognosis for the patient—should be

sufficient justification for reconsidering the disincentives to use this promising technology

From an economic perspective, the disincentives consequent to reducing reimbursement to the extent proposed by CMS for CAD (52%) and stereotactic guidance for percutaneous biopsy (80%), with the consequent increased resources that will be consumed for surgical biopsy and potential delayed diagnosed breast cancer are counter-productive in trying to reconcile budget issues to reimbursement schedules. From a patient perspective, the increased morbidity associated with surgical biopsy and potential lower cancer detection rates from the resulting restriction on the use of CAD technology are an unnecessary change that invites adverse consequences.

On behalf of the Society of Breast Imaging, I urge you to avoid these well-intended but misdirected initiatives in the current reimbursement schedule.

If I, or the Society may be of assistance to you, please do not hesitate to let me know.

Sincerely,

R. James Brenner, MD, JD, FACR, FCLM

President, Society of Breast Imaging

Submitter : **Mrs. Linda Zak** **Date: 08/16/2006**

Organization : **E. Penn Rheumatology**

Category : **Health Care Professional or Association**

Issue Areas/Comments

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

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

RE: CMS-1512-RIN 0938-A012 medicare program five-year review of Work relative vale units under the Physician Fee Schedule. Proposed change in reimbursement rate. The proposed reduction in reimbursement for doctors performing and reading Bone Denisty Tests would result in few women being tested. Many women would remain undiagnosed if access were restricted. As a certified R.T specializing in performing bone density tests , I see many women who have osteoporosis, and never suspected it. Many are only in their late 40's and early 50's. Undiagnosed osteoporosis and osteopenia would lead to a huge increase in future hip fractures, which would cost the healthcare system humdreds of millions of dollars to treat.

Please reconsider the huge reimbursement cut. Healthcare can't afford it.

Submitter : Dr. Robert Kosser

Date: 08/16/2006

Organization : Dr. Robert Kosser

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed reimbursement amount for CPT 93701 is not acceptable. My equipment expense for sensors and labor is increasing. My overhead and taxes are increasing. The cost of purchasing the machine was huge compared to the amount of the RVU amount that is being proposed. My patients derive much benefit from this test and I need to get paid more per test.

Submitter : **Ms. Elizabeth Hykes** **Date: 08/16/2006**

Organization : **Ozarks Medical Center, Behavioral Healthcare**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1512-PN
Costs are increasing for many reasons, not the least of which is increased fuel costs. Cutting reimbursement rates makes no sense. Please restore previous rates.

Submitter : **Dr. Sheila Rondeau** **Date: 08/16/2006**

Organization : **Presbyterian Inpatient Care Specialists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a hospitalist for the last 8 years, I was gratified to see interest in the revaluation of RVUs in inpatient internal medicine practice. I know, firsthand, the increase in complexity and management time necessary in the care of inpatients now as compared to pre-1999. As an example, just today, in the care of a 95 year old man who has several irreversible co-morbidities and fluctuating clinical status, I have spoken with family, hospice service, social work and nurse. Of couse I have rounded on this gentleman at the beside as well. Total time spent in this gentleman's end-of-life care so far today alone is two hours. I look forward to an improvement in reimbursement for the specialized hospital care I provide patients like this one.

Submitter : **Dr. Shane Petersen** **Date: 08/16/2006**

Organization : **Dr. Shane Petersen**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,

Although medical care costs continue to increase with advancing technology and superfluous profits by insurance companies and HMO's, I find it interesting that additional cuts are being directed towards physicians, especially in subspecialties that have been undervalued for decades by medicare. I have listed a few pertinent points to consider.

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

2- 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.

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

4- 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.

5- 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.

Thank you for your consideration of these pertinent points, suggestions, and fair solutions to mediate the rising costs of health care.

Shane Petersen, M.D.

Submitter : Dr. Rebecca Kurth **Date:** 08/16/2006

Organization : Rebecca J. Kurth MD, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am very concerned to learn about Medicare's proposed cut for re-imbursement for DEXA scanning for bone density assessment. This will have a significant impact on my ability to offer this important service to elderly and disabled patients. Medicare's current re-imbursement rates were already cut by ~10% in the past year. At that time, my office manager and I discussed whether I could continue in my current non-participatory status with Medicare or if I would be forced for economic reasons to resign. For the sake of patients with whom I have had more than a decade long relationship, I elected to continue in my non-participatory status. With escalating practice costs (for staff, insurance, benefits, Malpractice, etc), I can not afford to continue to provide high quality services for less financial compensation each year. I refuse to trade quality for volume. As with many physicians, I would prefer to opt out of the system than to compromise the care I give to my patients. As a general internist, my opting out will disrupt the care of many vulnerable elderly people. I enjoy my practice and spend long hours at it. I volunteer some of my time to teach at a local University hospital (as I value my role in educating future physicians). I am also a mother with 3 children. I need to make a reasonable income to support my family. Medicine is my calling but it is also my business, and I must make sound financial decisions to keep my business solvent. I do not think it unreasonable to expect fair payment for the services I provide. I participate in no other insurances so that I am already providing services to Medicare patients at substantially reduced fees. I do this because I feel physicians have an obligation to care for the poor, the elderly, and the disabled. Faced with the current proposed cuts, I and a number of my colleagues are poised to say "thanks, but no thanks" to Medicare. The hospital clinics and ERs, already overburdened, will have to carry the load when private physicians opt out of Medicare.

Submitter : Mr. Richard McDowell

Date: 08/16/2006

Organization : Kitsap Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

My name is Richard McDowell PT, MPT, MEd, OCS. I am a practicing physical therapist in the state of Washington. I am writing in concern of the June 29 voting to change RVUs under the physician fee schedule. It is my concern that cutting payment for licensed physical therapist is undermining the health care dollar. Physical therapists tend to get more face to face value with your clients. This allows for greater quality of service, reduced over all health care costs, and greater efficiency in the medical model. Currently Medicare reimbursement for services is at best a break even adventure. Here in a relatively rural community, we are one of the only providers covering these clients. It would make it difficult to continue to provide the same quality of care if fees are cut. This to me as a practicioner and a tax payer seems contradictory to what Medicare is supposed to be covering. It is my perception that a balance should be made between quality of care and cost. Currently this balance is tipped so that the quality of care in some cases is affected. If this continues to change it will not be a quality of care issue, it will become an availability of care issue as most if not all providers will be unable to provide services to these clients.

Submitter : **Dr. Kenneth Curl** **Date: 08/16/2006**

Organization : **Greenway Healthcare**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1600-Attach-1.WPD

AHealth
1600

Greenway Healthcare
1404 Willow Lane
PO Box 1303
N. Wilkesboro, N.C. 28659
336-667-0335

August 16, 2006

Center for Medicare & Medicaid Services
Department or Health and Human Services

Subject: CMS-1512-PN
Proposed changes to Medicare fee schedule

Dear Sirs:

It has come to my attention that the above proposed changes to physician fee schedule is being considered for approximate 80% reduction in technical portion in reimbursement for DXA scans and approximate 50% reduction in professional component for DXA scans. It's has also been brought to my attention that your studies were done to evaluate the cost of pencil-beam technology verses fan-beam technology which is used in my office and in virtually all systems utilized in current technology. My request is that you reconsider the severe reduction in reimbursements that are being proposed for several reasons as follows:

1. Fan-beam technology is must more expensive than pencil-beam technology and yet is much more sensitive and efficient and is much more widely used. It is significantly more expensive than the values that were used in your calculations for pencil-beam technology.
2. I have purchased a DXA scanner at considerable expense to myself. ($80,000 for the table and $4,400 per year for maintenance contract. Recouping this investment requires five or six years of reimbursements at the current level. Recoup of this expenditure would be impossible at the proposed levels of reimbursement.
3. Osteoporosis is a severe health problem in our aging population. Women and some men are severely handicapped with severe physical consequences of untreated Osteoporosis. With your current proposed reimbursement, DXA scans would simply go away and a large portion of our aging population as well as many a younger patients with metabolic problems would simply go undiagnosised. This would, in the long run, significantly increase the cost of medical care for these people who would suffer multiply fractures and impairment

of cardiac, pulmonary and gastrointestinal function as well as have severely limited lifestyles as a consequence of vertebral fractures and extremity fractures.

I can assure you that DXA scanning in my office has allowed the identification of Osteopenia as well as Osteoporosis in a large percentage of my patient population and the patients of other physicians as well. This identifying capacity has help to prevent long term problems and initiation of early preventive therapy for these patients.

I urge you to reconsider this reduction in reimbursement. It will definitely lead to a reduction in the quality of care provided to our patients and the millions of patients across this nation.

Thank you very much for you consideration.

Kenneth F. Curl

KFC/lm

Submitter : **Mr. Dave Gordon** **Date: 08/16/2006**

Organization : **Hillside Medical Office**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

We just purchased a new DEXA machine for our 7 doctor family practice clinic. It cost us about $80,000.00 not including remodeling we had to do in our small building to accomodate it. We put it in to provide necessary testing for our patients only. The proposed reduction in reimbursement will be very detrimental to our practice as we are independent and trying to survive on our own without being owned by a hospital or large multispecialty. Please reconsider the reduction proposed for CPT code 76075.

Submitter : **Dr. Steven Mawhorter** **Date: 08/16/2006**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

My goal - our goal, is to increasingly find opportunity to be effective and efficient in my pratice to alleviate current suffering, and to look for opportunity to avoid problems, maintain wellness, and increase the quality of life for everyone I care for. In fact E/M and RVU issues impact these goals and values.

As a cognitive specialist I find it increasingly challenging to be able to innovate and accomplish critical patient care coverage under the current system. Reflective of the skewed impact current E/M and RVU's have on cognitive infectious disease consultants; even practicing above the 80%ile RVU level ID groups such as ours suffer deficit accounting. The proposed changes (see below) will allow greater impact by key cognitive specialists on patient care. Fairer resource allocation will provide opportunity to further the proactive preventive, and wellness initiatives we seek to implement. If further cuts are implemented, then we will find ourselves further entrenched in a reactive posture, which is less than optimal for all.

CMS should finalize the E/M service codes work Relative Value Unit (wRVU) recommendations submitted by the American Medical Association's Relative Value Update Committee (RUC) and included in the Proposed Notice.
The E/M service code wRVU recommendations submitted by the RUC will help to guarantee patient access to cognitive specialties, such as infectious diseases, that have long been undervalued compared to their surgical colleagues.

Budget neutrality should be maintained through a change to the conversion factor rather than the 10 percent decrease in wRVUs proposed by CMS.
A wRVU adjustment will disproportionately impact those services with low practice expenses, such as the E/M service codes used by infectious diseases specialists.
Adjusting the conversion factor is a more appropriate way to address budget neutrality issues.
A conversion factor budget neutrality adjustment is preferable because it recognizes that budget neutrality is a fiscal issue, not an issue of relativity. The issue of relativity is also important because many private payers use the RVUs included in Medicare's physician fee schedule to determine their payment rates.

Sincerely,
Steven Mawhorter, MD, DTM&H

Submitter : **Dr. Thomas Roberts** **Date: 08/16/2006**

Organization : **IDIMA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to urge CMS to finalize the proposed RVU increases for E/M codes. Thank you.

Submitter : **Dr. Roger Gilbert** **Date: 08/16/2006**

Organization : **Radiological Associates of Sacramento**

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 to express my grave concerns regarding the consequences of the drastic cuts proposed for DEXA (Bone density scanning)reimbursement. If allowed to proceed, the result will be a loss of access to this important diagnostic modality which in the long run will lead to far higher medical costs to treat the fractures and disablity caused by osteoporosis.

Submitter : Dr. Roger Gilbert **Date:** 08/16/2006

Organization : Radioilogical Associates of Sacramento

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 to express my grave concerns about the potential loss of patient access to Stereotactic Breast Biopsy that will occur if the proposed drastic cuts in reimbursement go through. I have cared for numerous women who have been spared the morbidity of open breast biopsy by having the newer stereotactic approach available.
Thank you.

Submitter : **Dr. Lewis Dudley** **Date: 08/16/2006**

Organization : **RAS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:

I am a radiologist practicing in Sacramento, California.

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,

Lewis T Dudley, MD
Sacramento, California

Submitter : **Dr. William Swiggard**

Organization : **Cooley Dickinson Hospital**

Date: 08/16/2006

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am Infectious Diseases specialist in Western Massachusetts. My specialty consults involve detailed cognitive review and result in customized ecommendations that have proven benefit in shortening hospital stays, reducing complications and medical errors, and improving a variety of putcomes. My kind of "cognitive" work (like that of rheumatologists, endocrinologists, allergists and critical care specialists) does not involve billable procedures. It has unfortunately been undervalued and underpaid (compared to "procedure driven" specialties like surgery, cardiology, gastroenterology and pulmonary medicine) relative to the proven benefits which Infectious Diseases consultations provide - not just to patients, but to hospitals, communities and insurors, including Medicare. As a direct result of the relatively low financial rewards for pursuing this specialty, there is a shortage of Infectious Diseases specialists nationwide, as the number of threats to public health - antibiotic resistant organisms, emerging infections and bioterrorism among them - are increasing dramatically.

I urge CMS to implement and make permanent the proposed changes to the evaluation and management fee schedule.

In particular:

* CMS should finalize the E/M service codes work Relative Value Unit (wRVU) recommendations submitted by the American Medical Association's Relative Value Update Committee (RUC) and included in the Proposed Notice.
  o The E/M service code wRVU recommendations submitted by the RUC will help to guarantee patient access to cognitive specialties, such as infectious diseases, that have long been undervalued compared to their surgical colleagues.

* Budget neutrality should be maintained through a change to the conversion factor rather than the 10 percent decrease in wRVUs proposed by CMS.
  o A wRVU adjustment will disproportionately impact those services with low practice expenses, such as the E/M service codes used by infectious diseases specialists. Adjusting the conversion factor is a more appropriate way to address budget neutrality issues.
  o A conversion factor budget neutrality adjustment is preferable because it recognizes that budget neutrality is a fiscal issue, not an issue of relativity. The issue of relativity is also important because many private payers use the RVUs included in Medicare's physician fee schedule to determine their payment rates.

Thank you in advance for your attention - and for the careful review this matter deserves. I would be happy to discuss the issues further if that would be helpful. Please feel free to contact me personally.

William Swiggard
Northampton, MA

e-mail: swiggard@comcast.net
phone: (413) 582-9186
fax: (413) 584-4787

Submitter : **Dr. Aris Assimacopoulos** **Date: 08/16/2006**

Organization : **Infectious Disease Specialists, PC**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

CMS should finalize the E/M service codes work Relative Value Unit (wRVU) recommendations submitted by the American Medical Association's Relative Value Update Committee (RUC) and included in the Proposed Notice.
The E/M service code wRVU recommendations submitted by the RUC will help to guarantee patient access to cognitive specialties, such as infectious diseases, that have long been undervalued compared to their surgical colleagues.

Budget neutrality should be maintained through a change to the conversion factor rather than the 10 percent decrease in wRVUs proposed by CMS.
A wRVU adjustment will disproportionately impact those services with low practice expenses, such as the E/M service codes used by infectious diseases specialists. Adjusting the conversion factor is a more appropriate way to address budget neutrality issues.
A conversion factor budget neutrality adjustment is preferable because it recognizes that budget neutrality is a fiscal issue, not an issue of relativity. The issue of relativity is also important because many private payers use the RVUs included in Medicare's physician fee schedule to determine their payment rates.

Submitter : **Ms. Sheree Clyburne** **Date: 08/16/2006**

Organization : **Samaritan North Lincoln Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

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

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

To whom this may concern:
This comment is in reference to the proposed changes in the reimbursement for dexa scans. How can you justify limiting access to those people who need it the most after the Surgeon General himself declared Osteoporsis a national health problem? The financial burden on our health care system is already over-taxed...you would think that you would want to help eliminate the need for hospital stays and nursing home care after someone has broken a hip. Of course, you can always hope that the patient will die in the first year after the fracture...so that future medicare payments will not be needed. Is this your way to cut back on expenses? Please reconsider what you're doing and make the more humane decision to continue to cover these Dexa scan costs. Thank you for your consideration of this matter....
Sincerly, Sheree Clyburne RT(R)(M)(CT)

Submitter : Dr. Patrick Gray **Date:** 08/16/2006

Organization : Dr. Patrick Gray

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

You new methodology appears on the surface to more objective because it presumably is based on actual costs incurred to provide services. However, each code s RVU calculation is then artificially reduced to fit into CMS spending caps. This procedure, by definition, is severely flawed. I have news for you healthcare costs are rising every year for providers while you have proposed significant cuts in payment. Delay implementation of the new method to calculate RVU values until an appropriate amount of money has been allocated to pay for these procedures.

Submitter : **Mrs. Patricia Anderson** **Date: 08/16/2006**

Organization : **Women's Diagnostic Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1611-Attach-1.DOC

Attachmt
16/1

Women's Diagnostic Clinic, Inc., an independent, specialized diagnostic imaging office in Northeastern Ohio, **very strongly opposes the proposed CMS reduction in global reimbursement for dual energy x-ray absorptiometry (DEXA), CPT 76075 of the axial skeleton.**

***Women's Diagnostic Clinic, Inc.* believes these changes will have a significant negative impact on: women's access, women's health, and ultimately, CMS's future costs.**

Further, ***Women's Diagnostic Clinic, Inc.*** strongly believes that CMS should support all diagnostic imaging, by increasing reimbursements rather than decreasing. **WHY? DIAGNOSTIC IMAGING IS A CRITICAL PREVENTIVE TOOL as well as an EVALUATIVE TOOL in medical care.** CMS will ultimately **reduce its costs** by encouraging prevention, early diagnosis, and treatment.

PRACTICE EXPENSE:

Equipment: DEXA Scanners today have FAN BEAM TECHNOLOGY which is **more advanced**, provides **more detection**, with **more precision**, and **faster** than "pencil beam" (which is long outdated). COST: $60,000-$70,000.
UPGRADE COST: Up to $30,000 for detector upgrade package; $12,000 for diagnostic software upgrade package.

Maintenance, supplies, required Govt. inspections, clinical staff, administrative staff and overhead add from $50,000 to $150,000 annually for most places depending upon volume.

CONCLUSION: PRACTICE EXPENSE IS SIGNIFICANT FOR DEXA CPT 76075.
***Women's Diagnostic Clinic, Inc.* recommends increased reimbursement.**

WORK COMPONENT:

At ***Women's Diagnostic Clinic, Inc.*** a Board Certified Rheumatologist and Osteoporosis Specialist interprets all DEXA studies and recommends treatment for each patient to all referring physicians. He has prepared a detailed questionnaire for each patient to complete for his further review and to aid analysis. **His time spent on each case is significant.** THEREFORE, WE STRONGLY DISAGREE WITH THE RUC'S RECOMMENDED REDUCTION TO THE WORK RVU.

CONSEQUENCES IF PROPOSED REIMBURSEMENT CUTS ARE IMPLEMENTED:

1. **THE NUMBER OF PATIENTS SCREENED AND DIAGNOSED WILL BE DRASTICALLY REDUCED – AT A TIME WHEN THE AGING POPULATION IS GROWING! With the drastic proposed cuts, we will no longer be able to afford to offer DEXA services. Further, we will lose significant capital investment which would impact the viability of the entire office. Our office has been in business 19 years serving the entire West side of Cleveland and contributing to that economy with employment, local and government taxes, and the business relations with many**

other small businesses. OTHER OFFICES OFFERING QUALITY DEXA EXAMS WOULD ALSO BE FORCED TO STOP, LIMITING ACCESS TO PATIENTS.

2. **CMS'S COSTS WILL INCREASE. These proposed cuts are in direct opposition to multiple federal initiatives to reduce the personal and societal costs of osteoporosis. Approximately 23 million Americans are affected by osteoporosis with another 45 million at risk. Annual expenditures related to hip fractures alone exceed $18 billion AND ARE POISED TO INCREASE. - CURRENT UTILIZATION NUMBERS ARE ABYSMALLY LOW NATIONWIDE. Putting Medical facilities that offer DEXA studies to patients out of business will not help!**

   CMS should be focused on increasing awareness of DEXA screenings and access to these services. THE DECREASE IN REIMBURSEMENT WILL HAVE THE OPPOSITE EFFECT AND WILL RUN COUNTER TO THE GOALS OUTLINED IN THE U.S. SURGEON GENERAL'S REPORT FOR IMPROVING THE HEALTH AND QUALITY OF LIFE FOR OLDER AMERICANS AND REDUCING THE ECONOMIC BURDEN ON THE HEALTHCARE SYSTEM FOR OSTEOPOROSIS RELATED FRACTURES, ILLNESSES, AND CARE.

The tremendous progress of the last 10 – 15 years in developing technologies for the early detection of osteoporosis, along with effective therapies for treatment will have been in vain. CMS's proposed action is contrary to its public charter.

***Women's Diagnostic Clinic, Inc.* urges CMS to not reduce reimbursement at all for DEXA of the axial skeleton CPT 76075.**

Instead, CMS should support all diagnostic imaging, by INCREASING REIMBURSEMENT for all diagnostic imaging. DIAGNOSTING IMAGING IS A CRITICAL PREVENTIVE TOOL as well as an EVALUATIVE TOOL in medical care. CMS will ultimately reduce its costs by encouraging prevention, early diagnosis, and treatment.

Submitter : **Mr. Fred Gaschen** **Date: 08/16/2006**

Organization : **Radiological Associates of Sacramento**

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

Your decisions to gut women's diagnostic services leave me stunned. Everyone in healthcare knows that mammography is the #1 method for saving womens' lives from breast cancer. Early detection is the key and mammography does that inexpensively. In spite of testimony and publications supporting an INCREASE in mammography reimbursement, (e.g., you are not even paying the COST of the service right now) you have proposed a decrease in reimbursment. Why? What is the logic or rationale behind that recommendation? Access to quality mammograhy facilities has been a problem that you are in the process of exacerbating...

Continuing, what is the rationale for decreasing reimbursement for the least expensive and least invasisve form of breast biopsy - the stereotactic breast biopsy? Your proposal lowers reimbursement by 80% ove rthe next 4 years!!!! Why? Are you trying to channel women back into having surgical, open biopsies, with the co-committant morbity, not to mention the costs and psychological impact on the patients? 80% of all women who need a breat biopsy are candidates for a minimally invasive stereotactic breast biopsy, yet you are ensuring they will have less access to this proven procedure.

Lastly, what is up with your proposal to reduce dexa reimbursement? One of the most debilitating injuries to elderly women are hip fractures. Hip fractures can be minimized through the early detection of osteophorosis. Yet, this already inexpensive procedure is slated for a 71% reduction in reimbursement over 4 years. Our organization was planning on adding 3 more sites to our existing 5 throughout the greater Sacramento megalopolis and now we are going to add none. And, may have to close those that service mainly Medicare patients. So, fewer women will have dexascans and more women will have hip injuries, resulting in more hospital and SNF stays, and an overall INCREASE in the total cost of healthcare to MEDICARE.

If ever there were great examples of being penny wise and pound foolish, you guys at CMS are a lot worth studying. Do the math. Your proposals are decreasing reimbursement for preventive services that are already under reimbursed (mammography in particular). In the end I, as a tax payer, will pay the price as Medicare costs increase as a result of your decisions!

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

Organization : Mrs.

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

This letter is meant to voice my concern with the proposed 14 percent reimbursement cut. I have been a practicing Clinical Social Worker for 6 years, and have a new private practice. I enjoy my work, and am greatly concerned with my ability to continue doing what I do if this proposed reinbursement cut is passed. This proposed cut would drastically hurt my practice as I am a Medicare provider, and impair my ability to have my practice.
I am strongly urging and requesting that CMS not reduce work values for myself and all clinical social workers effective January 1, 2007.
I 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 request CMS not to approve the proposed 'bottom up' formula to calculate practice expense.
Please consider the selection of a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.
I will be monitoring this proposal along with my colleagues and the other Clinial Social Workers in Western Michigan. As a 10 year veteran in the Chicago-land area as well, we as Social Workers in private practice are greatly concerned and invested in our clients behavioral/mental health care and our ability to provide it.

Submitter : Dr. Barry Shapiro **Date:** 08/16/2006

Organization : Dr. Barry Shapiro

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

If the PE RVU proposal for CPT code 93701-TC goes through as is, my patients who are CMS beneficiaries will lose access to this test, as I cannot afford to do the test at a loss. I am urging you to reconsider.

Submitter : **Dr. Avi Ostrowsky** **Date: 08/16/2006**

Organization : **Dr. Avi Ostrowsky**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Your proposed payment for thoracic bioimpedance / cpt 93701 is not nearly enough to cover the costs of doing the test and paying for the equipment, etc.

Submitter : **Dr. David Linstadt** **Date: 08/16/2006**

Organization : **Dr. David Linstadt**

Category : **Health Care Professional or Association**

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 a Radiation Oncologist practicing in Auburn, California. Breast cancer and prostate cancer patients are my principal clinical focus. These diseases and the side effects of quality treatment frequently results in bone loss.

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,

David Linstadt MD
3320 Bell Road
Auburn, CA 9560

Submitter : Dr. Bruce Iteld

Date: 08/16/2006

Organization : Dr. Bruce Iteld

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

Fairness dictates a review of your proposed RVU value for CPT 93701-TC, the primary driver of payment for the global code of 93701. The fully implemented RVU value for this code of 0.64 is significantly less than the costs incurred by CMS providers to deliver the service. Therefore, there must be some mistake in your formula or problems with the costs and frequency of use you are using. Costs = $40K per device + $13 in consumables per test. Frequency of use is avrg. 2x per day, most often 4x per day. Please ask whoever gave you your costs to reconsider this one, the errors must be big.

Submitter : **Dr. James Blacksmith** **Date: 08/16/2006**

Organization : **Dr. James Blacksmith**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

There is a very large proposed cut in an important clinical test called impedance cardiography / thoracic bioimpedance, the cpt code is 93701. If all goes through at the rates that were listed, you need to know that the test will not be able to be done by existing providers with this capability and no provider will be able to add this service. Is that the intention of your proposed cut? If not please revise the RVU to at or above its current level, which is already too low.

Submitter : **Dr. Lawrence Cox** **Date: 08/16/2006**

Organization : **Dr. Lawrence Cox**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I am requesting that you review of the cut to CPT code 93701 on the practice expense side of things. I want to know that I know 6 physicians in addition to myself who have purchased this device for more than the $28,000 that you estimate its cost to be. Are you purposely putting a lower figure / older figure in to reduce payment? If not please revised it to reflect the actual costs of $41,000 to $46,000.

Submitter : **Dr. David Booth, II** **Date: 08/16/2006**

Organization : **Dr. David Booth, II**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Dear Sirs. You are making a serious error by assuming that CPT code 93701-TC has a utilization rate of 50%. In fact, it is only 8 to 10% of the time in a standard five-day week that this equipment is even POSSIBLE to be used on patients, let alone a real estimate of its average use. In addition, very few private insurance payors cover the test, so Medicare patients tend to be the only ones it can be done on.

Submitter : **Dr. Ronald Koff** **Date: 08/16/2006**

Organization : **Dr. Ronald Koff**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I have been informed by the manufacturer of my bioimpedance monitor (corresponding to CPT 93701) that CMS has proposed the RVUs and payment be cut in the years 2007, 2008, 2009, and 2010. Please do not do this. The equipment cost is much higher than you estimate (whose survey did you use, anyway, it must be very old) and their special sensors cost more than you estimate at $9.95.

Submitter : **Ms. Aline Snoeyink** **Date: 08/16/2006**

Organization : **Rehab Pros**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

I am a physical therapist assistant practicing in an assisted living/skilled nursing unit. I have been practicing for 10 years in various settings, including head injury, acute rehab, acute care and home care. I have witnessed first hand and experienced the impact physical therapy and other non-physicians services can have on an individuals life. It can mean improving or preserving function to enable a person to stay in their own home vs assisted living, or stay in assisted living vs a nursing home. It can make a difference whether a person returns home from a nursing home, thus in turn saving medicare thousands of dollars.

I wish to comment on the June 29th proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physicians fee schedule.

I strongly urge you to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007.

A transitioning of the changes to the to the work relative value units over a four year period would ensure that patients continue to have access to valuable health care services.

Under current law, the SGR formula is projected to trigger a 4.6% cut in payments in 2007. It is unreasonable to propose policies that pile cuts on top of cuts, as the 5-year review rule would impose additional cuts on top of the SGR.

Physical Therapists will derive no benefit from increased payment, as they cannot bill for E/M codes. Although physicians services are important, and better management of services do result in better outcomes, physicians rely heavily on physical therapy intervention to improve outcomes and enable a highter level of independance. Physical therapists spend a considerable amount of time in face to face consultation and treatment time with patients. Time that is individualized to ensure progress. Our services are essential to ensuring the outcomes anticipated by the physician. Severe cuts for these services will jeopardize access to care of the elderly and disabled.

Thank you for taking the time to read my comments,
Sincerely,
Aline Snoeyink, PTA

Submitter : **Mrs. Mary Nickliss** **Date: 08/16/2006**

Organization : **Mrs. Mary Nickliss**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1512-PN

Dear Center for Medicare & Medicaid Services August 15, 2006

I am a Certified Densitometry Technologist practicing at the Osteoporosis Center of Lancaster, PA.

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,

Mary Nickliss
72 Robinhill Drive
Lititz, PA 17543

Submitter : **Dr. Joseph Havlik** **Date: 08/16/2006**

Organization : **West Georgia Infectious Diseases**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

We are unable to cover the expenses to run our office and outpatient infusion on Medicare and Medicaid payments. This applies especially to HIV and AIDS patients.

Submitter : **Ms. Helen Hoffman** **Date: 08/16/2006**

Organization : **Ms. Helen Hoffman**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

As a Medicare privoder already accepting a rate from Medicare that is less than my regular fee this new 14 percent reimbursement cut will have a very negative impact on my practice. I insist that CMS not reduce work values for clinical social workers effective January 1, 2007;
Instead CMS should withdraw the proposed increase in evaluation and management codes until they have funds to increase reimbursement for all medicare providers. Please do not to approve the proposed "bottom up" formula to calculate practice expense. Please select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Submitter : **Mrs. Andrea Moon** **Date: 08/16/2006**

Organization : **Aurora Family Medicine Center**

Category : **Physician Assistant**

Issue Areas/Comments

Other Issues

Other Issues

To whom it may concern:

This letter is in response to the proposed cuts by Medicare for 2007 regarding Bone Mineral Densitometry (BMD) CPT code 76075 and CMS 1512-PN. This letter focuses on the work component portion of the proposal.

Approximately 25% of our patients are enrolled with Medicare for health insurance and preventative health services. Many of these patients are women who rely on BMD and dual x-ray absorptiometry (DXA) as part of the screening and/or management of disease processes. Our practice owns a machine which 1 out of 6 providers and 1 medical technician are qualified to use. To ensure accurate screening, both have already attended two 8 hour seminars including introduction to densitometry and radiation safety. In October both will be attending a two day conference for Colorado state certification, which is now being required by several other insurance carriers.

While we would like to continue providing BMD/DXAs at our office for our patients, this proposed cut in reimbursement would put our ability to continue screening in jeopardy. Having to spend 20 minutes performing a DXA scan under the proposed reimbursement reduction would not be economically feasible for our practice resulting in a loss of the screening process for a preventable disease. For example, a patient who should have been screened for bone loss, but was not due to these proposed changes, might unnecessarily suffer an otherwise manageable condition such as osteoporosis or even worse a hip or spine fracture.

In closing, our practice would highly recommend against the proposed changes to reimbursement on the BMD scans as it would not only effect our ability to practice medicine, but would alter our patient s wellbeing.

Thank you,

Andrea P. Moon PA-C, MS
Aurora Family Medicine Center, P.C.
1421 South Potomac Suite #320
Aurora, CO 80012
303-750-1920
ands55@aol.com

Submitter : Dr. James MacKenzie **Date:** 08/16/2006

Organization : Michigan Medical Doctors, PLLC

Category : Physician

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

The proposed reduction in Physician Fee Schedule (CMS-1512-PN, RIN 0938-A012) is unreasonable with respect to DXA of the axial skeleton (CPT 76075). The CMS study underestimated the costs associated with this procedure. The equipment used by almost all physicians is a more expensive fan-beam scanner, not the pencil-beam scanner assumed in the study. This scanner costs nearly $100,000 to purchase and $6 - 10,000 annually in maintenance costs. With the requisite technician costs, lease expenses and physician interpretive costs, the proposed reimbursement would not even cover the fixed expenses associated with this procedure.

The reimbursement for this procedure, which can not be performed more often than every two years on any Medicare recipient, should not be not be reduced by any greater percentage than other reimburable procedures.

If physicians are not paid some reasonable amount for DXA scans, they will not be able to continue to diagnose women and men with osteoporosis. The condition will be under-diagnosed, and under-treated in the elderly population. With neglect of treatment of osteoporosis, more hip and skeletal fractures will occur, with increased mobidity, and medical and nursing home expenses resultant.

Please consider a reasonable adjustment to the DXA reimbursement schedule.

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

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Practice Expense

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Please consider a reasonable adjustment to the DXA reimbursement schedule.

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

Organization : **Camino Medical Group**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

CMS should finalize the E/M service codes work Relative Value Unit (wRVU) recommendations submitted by the American Medical Association's Relative Value Update Committee (RUC) and included in the Proposed Notice.

The E/M service code wRVU recommendations submitted by the RUC will help to guarantee patient access to cognitive specialties, such as infectious diseases, that have long been undervalued compared to their surgical colleagues.

Budget neutrality should be maintained through a change to the conversion factor rather than the 10 percent decrease in wRVUs proposed by CMS.

A wRVU adjustment will disproportionately impact those services with low practice expenses, such as the E/M service codes used by infectious diseases specialists. Adjusting the conversion factor is a more appropriate way to address budget neutrality issues.
A conversion factor budget neutrality adjustment is preferable because it recognizes that budget neutrality is a fiscal issue, not an issue of relativity. The issue of relativity is also important because many private payers use the RVUs included in Medicare's physician fee schedule to determine their payment rates.

Submitter : **Dr. ALAN SANDERS** **Date: 08/16/2006**

Organization : **UPSTATE INFECTIOUS DISEASES ASSOCIATES**

Category : **Individual**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

As an Infectious Disease practitioner, in practice for the last 12 years, I have been entrenched in an increasingly complex world of resistant bacteria and lethal infections. The current E/M stucture and payment model does not take into account the added cognitive and diagnostic requirements in the field of Infectious Diseases. We are called upon to care for more debilitated, immunocompromised, and complex patients than ever before, and along with this the added burden of limited antibiotic choices and design of novel regimens for treatment.
The infectious disease specialist is clearly spending greater problem -solving time in the hospital today than other specialties in medicine and surgery, and thus deserves a unique, and heightened reimbursement schedule than the other physicians who depend greatly on our care in treating their patients.

Submitter : **Dr. Timothy Brennan** **Date: 08/16/2006**

Organization : **Univ of Iowa**

Category : **Individual**

Issue Areas/Comments

Practice Expense

Practice Expense

Dear Sir:

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.

Submitter : **Dr. Timothy Brennan** **Date: 08/16/2006**

Organization : **Dr. Timothy Brennan**

Category : **Physician**

Issue Areas/Comments

Background

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Submitter : **Ms. Thelma Rosenberg** **Date: 08/16/2006**

Organization : **Thelma Rosenberg**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

My practice consists of providing psychotherapy services to the homebound elderly. A cut in Medicare reimbursement will be a hardship for me and the clients I serve, impacting my ability to continue to practice and still make a living. It is extremely important to approach any increase or decrease in payment equally between all professionals. In working with the elderly, I often help them in their medical decision making processes. Many are isolated and without any support systems or family and find the service I provide one of the few supports in their life.

Submitter : Dr. George Heffner Jr **Date:** 08/16/2006

Organization : -

Category : Physician

Issue Areas/Comments

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

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

I do believe that imaging studies are all over reimbursed. However, I think the expected reductions for DXA will effectively limit access as only very high volume centers will survive

Submitter : **Dr. Timothy bRENNAN**

Organization : **Univ of Iowa**

Date: 08/16/2006

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Gynecology, Urology, Pain Medicine

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