Submitter : Ms. Lynne Slater **Date:** 08/16/2006

Organization : private practise

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

As a clinical social worker in private practise,i would like to take the opportunity to respond to the proposed 14% cut for social workers in Medicare reimbursements. I feel that this is quite out of line, particularly when compared to other providers percentage changes. The reduction in income will surely effect my practise and the scope of services I provide. This seems especially unfair when one considers the already disparate amount that clincial social workers recieve versus psychiatrists etc. Additionally, I believe this should be withdrawn until such time as reimbursements are more equitable across the board. I have been practising social work for over 25 years and have never actually received a pay increase from insurance companies, including Medicare, however I most certainly have received pay decreases; this does not seem at all appropriate or acceptable and especially when other expenses continue to increase. I believe it is my integrity on the line here when clients and I work together, and so I would never refuse to treat a client because their insurance company has dropped their fee, however it is quite distressing to me that my discipline gets such little respect that this would be acceptable to health care/insurance providers and companies.

Submitter : Ms. Ethel Barber **Date:** 08/16/2006

Organization : Private Practice

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I write to alert you that limiting the reimbursemnts for treatment of clients of social workers will cause me to limit my practice as I will have to take patients who are able to pay. I must make a living. Congress does not lower their compensation!

Clients need to have access to the support and assistance clinical social workers provide.

Submitter : **Ms. Joan Shapiro** **Date: 08/16/2006**

Organization : **Self Employed**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Regarding CMS 1512 PN

I am a licensed clinical social worker serving both elderly and mentally ill patients insured by Medicare. I am writing to ask that you NOT cut work values for clinical social workers effective Jan 2007, and that you withdraw the proposed increase in evaluation and management codes until there are adequate funds to increase reimbursement for all Medicare proviers. A 14 per cent decrease in Medicare reimbursements not only threatens my personal ability to retain Medicare my status as a Medicare provider, but forces those delivering exemplary care to think to forego serving the needs of this vulnerable group. Social workers are the bread and butter of mental health care and should not be penalized by CMS, but encouraged to continue to do so via reasonable reimbursement for services. I thank you for your consideration.

Sincerely,

Joan E. Shapiro, LCSW,BCD

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

Organization : Charis Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern,

I was licensed in January 2005. I have a long history of working with the poor, mentally ill and disabled. I can't understand why we as a society would ever consider impacting this population of people. It isn't about us, the social workers. It is about the needy, vulnerable, disabled, elderly population. We already only get approximately $32.50 to see a client on an outpatient mental health basis. Worsening this benefit to social workers sounds like a senseless act to me. Even if it is indirectly affecting us, what is the incentive for others to help this population especially those who prefer to cater to the rich. I do much pro bono work and make little money. This proposed effort is a disgrace, I feel. If I don't understand the motive behind this effort, I apologize, but if it limits services in any way it just doesn't make any sense to me.

Diane K. Brantley LCSW

Submitter : Ms. gay novack **Date:** 08/16/2006

Organization : Ms. gay novack

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

As a practicing clinical social worker for 28 years, on behalf of my clients and as a child of parents, etc. who use Medicare, and as future recipient of Medicare coverage -- I want to make the point that clinical social workers are among the most available, as well as well-trained mental health professionals who are most suitable for meeting the mental health needs of the Medicare recipient population due to our training in treating the whole person - the ecological perspecitve. CMS should take this into full consideration when assessing the work values for clinical social workers ---if anything, social workers deserve increases in their reimbursement rates due to the value of their contribution . CMS certainly should not reduce work values for clinikcal social work services - which will ultimately diminish the number of well-trained professionals available to the Medicare poplulation.

Other Issues

Other Issues

Please withdraw the proposed increase in evaluation and mangaement codes until there are enough funds to increase reimbursement for all Medicare providers.

Practice Expense

Practice Expense

Do not approve the proposed 'bottom up' formulas 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 : Dr. Lisa Vasak **Date:** 08/17/2006

Organization : Dr. Lisa Vasak

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

Advancing technology, direct to consumer advertising, internet accessibility and increasing age of the general population are all reasons that the time required to take care of individual patients in a primary care practice is increasing. I have been in practice for 11 years. I have seen dramatic changes in my time commitments and requirements in my Internal Medicine practice. I am uring CMS to finalize the recommended work RVU increases for E/M services. These changes will help assure continued access to primary care services. Over the past few years, my overhead consistently increases whereas my practice reimbursement is staying steady or decreasing. I will not be able to continue seeing Medicare patients if reimbursements are not adjusted in an upwards direction. I urge CMS to reject any comments that would lower the overall improvemts in work RVUs for E/M services.

Submitter : Dr. Mahalakshmi Honasoge **Date:** 08/17/2006

Organization : Henry Ford Health System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,
until socialized medicine becomes a reality it is not fair to transfer all the burden of govt deficits on intitutions and physicians.The technical revenue for DEXA reports is minimal and effort needed to ensure quality and send out a report even if it is a direct print out from the machine deserves better remuneration than what is being proposed. Physcicians need not have to be cornered to this extent.

Submitter : Dr. Tamara Vokes **Date:** 08/17/2006

Organization : University of Chicago

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-1643-Attach-1.PDF

CMS-1512-PN-1643-Attach-2.PDF

Attach #
1647

Dear Dr. McClellan:

I am an endocrinologist practicing at the University of Chicago.

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 can give you numerous examples where the bone density testing has made a tremendous impact on patient care. Recently, I had an elderly patient completely debilitated by osteoporosis – she had multiple vertebral fracture, hip fracture, loss of mobility and inability to do all of the things that she enjoyed doing. She was slowly dying of osteoporosis. Her daughter was at the appointment with her. She was a strong, healthy woman in her 50ties. She thought that she was protected from her mother's fate because of strong constitution. I suggested that she get bone density testing and found that she had very significant osteoporosis that puts her at a significant risk of fractures. As a result of bone density testing she is now receiving potent and effective therapy which I believe will prevent fractures and enable her to enjoy her old age without the burden of and suffering associated with fractures.

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,

Tamara Vokes, M.D.
Associate Professor of Medicine
University of Chicago
Section of Endocrinology
5841 S. Maryland
Chicago, IL 60637

Submitter : Dr. Michael Kelly **Date:** 08/17/2006

Organization : Dr. Michael Kelly

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

Dear Sir:
I am a hospitalist practicing in Tacoma, WA. Over the last decade it has become harder and harder for me to obtain subspecialty consultations on my inpatients because of the economic disincentive to provide services in the hospital setting because of the disperity in reimbursement between inpatient and outpatient reimbursement for E/M services. Specialists simply decline to provide inpatient services. I have even had to transfer patients to academic centers because physicians in my community decline to provide inpatient services on a regular basis. Improving reimbursement for inpatient E/M services will improve access to inpatient subspecialty services for patients in my community.

Furthermore, my own inpatient services are subsidized by my hospital because inpatient services are reimbursed so poorly that my practice would not be feasable otherwise. Improving inpatient E/M reimbursement will allow me to see fewer patients per day thus increasing the amount of time I can devote to each patient. This would result in improved quality of care as well as improved efficiency of care.

Inpatient E/M services is the least profitableline of business for internists. It has the lowest reimbursement rate, the lowest collection rate, the highest medico-legal liability risk and the worst hours. No wonder doctors don't want to practice there! Improving reimbursement in this setting will go a long way in reversing the trend of declining quality of physician services that I have witnessed in the last 15 years. You may be hospitalized someday too. I urge you to approve the recommended changes to inpatient E/M services RVUs.

Submitter : **Tamara Vokes** **Date: 08/17/2006**

Organization : **university of chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:
I am an endocrinologist practicing at the University of Chicago.
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 can give you numerous examples where the bone density testing has made a tremendous impact on patient care. Recently, I had an elderly patient completely debilitated by osteoporosis slowly dying from it. Her daughter was a strong, healthy woman who believed she had no such risks becuase of her heavy weight and good activity level. I suggested that she get bone density testing and found that she had very significant osteoporosis that puts her at a significant risk of fractures. As a result of bone density testing she is now receiving potent and effective therapy which I believe will prevent fractures and enable her to enjoy old age very different from her mother's.
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

CMS-1512-PN-1645-Attach-1.PDF

1645

Dear Dr. McClellan:

I am an endocrinologist practicing at the University of Chicago.

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.

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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,

Tamara Vokes, M.D.
Associate Professor of Medicine
University of Chicago
Section of Endocrinology
5841 S. Maryland
Chicago, IL 60637

Submitter : Mrs. glennie feinsmith **Date:** 08/17/2006

Organization : NASW

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed reduction to the fees paid to social workers will most likely curtail my ability to see Medicare patients. With all of our practice expenses going up your considering a reduction while you increase fees paid to physicians seems ludicrous. Please reconsider.

Submitter : **Dr. Jeffrey Kuo** **Date: 08/17/2006**

Organization : **Radiological Associates of Sacramento**

Category : **Radiologist**

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 radiologist practicing in Sacramento, CA.

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.

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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,

Dr. Jeffrey Kuo
1500 Exposition BLvd
Sacramento, CA

Submitter : Dr. Peyman Markazi **Date:** 08/17/2006

Organization : Albert Einstein Medical Center

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I am writing to support the proposed changes to the E/M work RVUs in the 2007 physician fee schedule. I strongly believe the increases in the E/M services are needed for many reasons. First of all, there has been an increase in the complexity of the care provided to hospitalized patients in this country. Most patients present with great burdens of illness, and with more complex presentations requiring more comprehensive care. This complexity has increased progressively over the past 5 to 10 years, increasing the burden on health care providers, and the system as a whole. With the ever increasing obesity epidemic and it's associated comorbidities, not limited to heart disease, stroke, diabetes, and cancer, more patients now are presenting with multiple simultaneous medical issues. In addition, as the primary care providers are forced to take care of sicker patients in the community, hospitalists are being pressured to limit their care to the very sickest amongst are population of patients.

Please reject any efforts to lower overall improvements in work RVUs for E/M services. Any lowering of these improvements will greatly diminish the quality of care that hospitalists in this country can provide. What we need to strive for is to improve upon the high quality health care that is already being given to our patients, and to ensure that the resources and funds are available to build upon this in the future.

Thank you very much.

Submitter : Ms. TANNA PATE **Date:** 08/17/2006

Organization : BLANCHARD VALLEY REGIONAL HEALTH CENTER

Category : Other Technician

Issue Areas/Comments

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

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

I RECOMMEND that CMS withdraw its proposed 54% reduction for the technical componet of CAD until such time that providers can differentiate between the utilization of CAD with anolog or digital mammography. All CPT codes for CAD contain the phrase,"with or without digitization of film radiographic images".

Thank you,
Tanna Pate, R.T.R.M

Submitter : **Date: 08/17/2006**

Organization : **Ingalls Memorial Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Your proposed changes for reimbursement of the DXA exam for bone density loss will have a negative impact on women's health. The reductions for reimbursement will make this exam become extinct. The technology and the data base that have been procured over the past several years, will have become fruitless. Please consider the strides that have been made in this technology.

Submitter : **Date: 08/17/2006**

Organization :

Category : **Other Technician**

Issue Areas/Comments

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

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

The proposed changes in the Medicare reimbursement for dual x-ray absorptiometry if adopted, I believe will have a significant negative impact on patient access to osteoporosis screening. There are errors by the CMS as to the assumptions regarding operating costs and utilization of DXA systems. There is a serious underestimation of the actual costs of providing state of the art osteoporosis screening.

Submitter : **Dr. Richard Clouse** **Date: 08/17/2006**

Organization : **Dr. Richard Clouse**

Category : **Physician**

Issue Areas/Comments

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

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

Richard M. Clouse, MD
1330 N. Race St.
Glasgow, KY 42141
(270) 651-6791
rmcmd1979@aol.com
8/17/2006

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

Dear Sirs:

I am writing in attempt to halt the proposed change of fee schedule for performing DEXA scans. DEXA scanning is used in an attempt to diagnose osteoporosis in an early stage in order to provide appropriate care in a timely manner. As you know osteoporosis has significant cost to women in the US. Numerous studies show that early detection and prevention of osteoporosis saves millions of dollars in both acute and long term care of women in the United States. The cost in quality of life resultant of a vertebral or hip fracture is incalculable.

According to my information as per CMS-1512-PN, RIN 0938-AO12 the reimbursement reduction for providers will significantly decrease. This in turn most assuredly will lead to less availability as this service as the cost of acquiring the technology and its maintenance would be prohibitive. Actions like this would be especially damaging to rural communities where women s health care is already scarce. Women would have to travel great distances to have this essential procedure performed. This would result in less testing and intervention. Hospital and Nursing home admissions would increase forcing health care costs higher.

The fee reduction proposed in CMS-1512-PN would more than likely result in far greater costs to an already stretched health care system. This would also be a disservice to women s health care as a whole as well.

I urge you to reverse the reduction proposed by CMS-1512-PN. I urge you to help us maintain State of the Art Quality women s health care.

Sincerely,

Richard M. Clouse, MD

CMS-1512-PN-1652-Attach-1.DOC

H Ha 11 ##
1652

Richard M. Clouse, MD
1330 N. Race St.
Glasgow, KY 42141
(270) 651-6791
rmcmd1979@aol.com
8/17/2006

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

Dear Sirs:

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The fee reduction proposed in CMS-1512-PN would more than likely result in far greater costs to an already stretched health care system. This would also be a disservice to women's health care as a whole as well.

I urge you to reverse the reduction proposed by CMS-1512-PN. I urge you to help us maintain "State of the Art" "Quality" women's health care.

Sincerely,

Richard M. Clouse, MD

Submitter : Mr. Gordon Rhoades **Date:** 08/17/2006

Organization : Diagnostic Center of Indiana (The Care Group, LLC.

Category : Other Technician

Issue Areas/Comments

Practice Expense

Practice Expense

In reference to this item, I would like to make the following comments.

1) I have been a Radiologic Technologist for 26+ years and can say that this will greatly reduce the efficient availability of services to individuals. Hospitals in my area have long waiting lists for services and people often are required to wait for extended times when arriving for scheduled appointments. This is due to very frequent emergency procedures that require immediate attention and are not able to be scheduled.
2) The requirements placed by the general public and often by liability insurance carriers require that all facilities that provide imaging services provide the latest technology in order to insure proper diagnoses. This is expensive and the continued training of technologists adds to the expense. Also, each imaging technologist, regardless of the modality, is required to maintain continuing education. As both a "Registered Radiographer" and a "Certified Densitometry Technologist" I am required to spend nearly $150.00 per year to maintain these important requirements. My current employer does not cover this as my base pay is intended to cover these costs.
3) As for DEXA scanning specifically, I have been performing this procedure now for the past year. This particular facility performs more than any other in our city to my knowledge. That would be an average of 8 patients per day. I need to spend no less that 30 min per patient to make certain that they are well informed about their own part in keeping their bones healthy. I know that this has been of particular interest to many people since the Surgeon General's Report on Bone Health and Osteoporosis was released in 2004. It is a great thing that our government has taken an proactive interest in preventing the fractures that occur from osteoporosis, as demonstrated by the Bone Mass Measurement Act in place since July 1998. However, there are very few DEXA systems operated by hospitals, which would be minimally affected by the proposed changes in reimbursement rates. The outpatient imaging centers and other facilities currently provided the vast majority of DEXA scans will be prohibited from providing this service if the global reimbursement rates for CPT 76075 are reduced to the proposed rate somewhere around $30.00 per procedure.

I consider it such a privilege to provide this service. I am able to spend time assisting my patients in obtaining answers to their questions. I perform a procedure that will certainly help to prevent the debilitating conditions caused by hip fractures and spinal compression fracture. If the reimbursement rate is decreased to the proposed value, my facility will either be required to discontinue providing this service or increase the number of exams per day. This will require limiting the amount of time I spend with each person to less that 15 min. This is barely enough time to perform the procedure on someone that is very mobile. It would not allow adequate time to discuss life style changes and other risk factors.

There are some facilities that are able to perform Vertebral Fracture Analysis. This procedure allows the evaluation of the severity of spinal compression fractures. It is invaluable to many physicians in determining the efficacy of such valuable procedures and vertebroplasty and kyphoplasty. The reason that our facility does not currently perform this procedure is the extreme expense of updating our equipment. With the nearly $80,000 price tag to do so, we would have difficulty justifying this expense with the current reimbursement rate and most certainly will not even be able to consider providing this service if it is reduced to the proposed rate. Thank you for your time and attention to this matter. I really believe that such severe cuts in rates will result in severely limiting the availability of imaging services in general and DEXA in particular.

Sincerely,

Gordon L. Rhoades, BS RT(R), CDT

Submitter : Dr. William Burns **Date:** 08/17/2006

Organization : NE Georgia Diagnostic Clinic

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I have been practicing medicine for over 40 years with a specialty in Internal Medicine. During this time I have seen the implementation of the Medicare Program and I have seen my specialty utterly decimated by the unfair payment practices that grossly overvalue procedure based medicine and give little value to the cognitive skills of many of our physicians. The complexities of practicing under today's system of payments and the increasing complexities of the practice of internal medicine have placed huge time loads on our physicians that never existed before. Furthermore, the distortions created by the Medicare payment system which richly rewards procedures and almost penalizes physicians who use their time to think, research, and actually spend time counseling patients have only encouraged physicians to seek out new 'gimmicks' with questionable benefits that then lead to the very cost increases and abuses that Medicare purports to be trying to control.

I urge the commission to realize what the past errors have created and how these errors have warped the practice of medicine to the detriment of this nation and to the detriment of the patients. I urge you to properly value the Evaluation and Management services that physicians do. I believe that if you do this, it will be a step toward discouraging this never ending spiral of increasingly costly procedures and their attendant costly equipment and secondary costs. In doing so you will benefit this nation and Medicare's patients.

Submitter : Ms. Anne Marie Bicha **Date:** 08/17/2006

Organization : American Gastroenterological Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1512-PN-1655-Attach-1.DOC

1655

August 17, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1512-PN
P.O. Box 8014
7500 Security Boulevard
Baltimore, MD 21244-8014

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

Dear Dr. McClellan:

The American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and the American College of Gastroenterology (ACG) welcome the opportunity to comment on the proposed changes to the physician fee schedule for 2007. Our three societies represent virtually all practicing gastroenterologists in the United States.

Practice Expense

We are pleased that CMS has proposed to implement the supplemental practice expense survey data for gastroenterologists. This data was, of course, also accepted for the 2006 proposed rule. However, when CMS decided not to implement any of the practice expense methodological changes for 2006, use of the supplemental survey data was tabled for the final rule. It is our understanding that our new survey data will be used in the calculation of indirect expenses only and will be subject to the four-year transition with the other practice expense changes; i.e., the elimination of the non-physician work pool, the change to the bottom-up method for direct expenses and the changes in the method for allocating indirect expenses.

In light of the substantial re-distributional impact flowing from the changes in the practice expense methodology, we understand why CMS wants to temper the effects by phasing in the changes over a four-year period. As noted above, the gastroenterology survey data was originally proposed to be utilized for 2006. In addition, supplemental surveys accepted by CMS for other specialties in prior years including, most recently, the supplemental data for oncology,

was utilized without being subject to a transition period. Finally, gastroenterology services are not assigned to the non-physician work pool. We, therefore, recommend that CMS implement the new supplemental survey data for 2007 with no transition period.

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

There are four codes commonly performed by gastroenterologists that were surveyed in the five-year review process: 43235 (upper gastrointestinal endoscopy, diagnostic); 43246 (Upper gastrointestinal endoscopy, with directed placement of percutaneous gastrostomy tube); 45330 (diagnostic sigmoidoscopy) and 45378 (diagnostic colonoscopy). We are pleased that CMS agreed with the RUC that the physician work values for these procedures should be maintained at their current values.

Other Issues Under the Five-Year Review

The GI societies would like to indicate our support for the proposed increases in the work values for certain evaluation and management codes. We understand that due primarily to the increases in the work values for the E&M codes, a substantial adjustment is needed to maintain budget neutrality in overall physician spending. CMS currently proposes to accomplish this by imposing a reduction of about 10 percent in all physician work values. However, CMS requests comments on the alternative of achieving budget neutrality for the net increases in physician work values by reducing the conversion factor by an estimated five percent. We gather that either method would satisfy the statutory requirement to preserve budget neutrality when changes occur in relative values leading to $20 million or more in expenditures.

We strongly urge that CMS adjust for budget neutrality by reducing the conversion factor and not by reducing the physician work values. Our rationale is as follows:

- It has been Medicare policy for many years that work neutrality adjustments would be made through the conversion factor. We recognize that for the first five-year review, CMS implemented a separate work adjustor. CMS indicated that the separate work adjustor proved very confusing and in 1999, CMS converted the work adjustor to an adjustment to the conversion factor. In fact, since 1998, CMS has implemented all work neutrality adjustments through the conversion factor.
- Adjustment of the work values, even if done as a separate adjustment and not reflected in Addendum B, could lead to undesirable effects outside of Medicare. For example, it could lead to inappropriate reductions in the fees paid by other third party payers. In addition, the Medicare relative value scale is used for a variety of other purposes such as in determining compensation levels in academic and group practice settings. A separate work adjustor could distort these arrangements in unintended ways.
- The proposed work adjustor would substantially erode the long-overdue increases proposed in payment for evaluation and management services.
- We understand that CMS is of the view that if budget neutrality is to be maintained for the work value increases though the conversion factor that consistency might dictate that

the same be done for adjustments made for practice expense values. We think, however, that a clear distinction can be drawn between work value and practice expense adjustments.

First, the practice expense system is still very much in a state of flux. In fact, as proposed there stands to be a four-year transition to the new system. Second, the historic precedent for adjusting the conversion factor does not exist in the case of the various steps in the practice expense calculation such as the adjustment of the PEAC cost data to the allowable pool of direct expenses. Finally, we do not think the various adjustments made in the calculation of allowable practice expense values has the same impact on other payers and private contracts as is present with adjustments to work values.

For all of these reasons, we strongly urge that CMS maintain budget neutrality for changes in work values by adjusting the conversion factor.

Thank you for the opportunity to submit these comments. If we may provide additional information, you may contact Anne Marie Bicha, AGA Director of Regulatory Affairs, at 240-482-3223, Bernard Patashnik, Consultant to ASGE at 202-833-0007, or JoAnn Willis, ACG, at 301-263-9000.

Sincerely,

Jack A. DiPalma, MD, FACG
President, American College of Gastroenterology

Gary W. Falk, MD, FASGE
President, American Society for Gastrointestinal Endoscopy

David A. Peura, MD
Chair, American Gastroenterological Association

Submitter : Dr. Brenda Peacock **Date:** 08/17/2006

Organization : Washington Women's Care

Category : Physician

Issue Areas/Comments

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

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

A cut in reimbursement for DXA performance and interpretation would have a significant adverse impact on strides made to date in earlier detection and treatment of osteoporosis. There are already poor interpretations at non certified facilities, this would make efforts at proper training less desirable.

Submitter : Dr. Paul Carson **Date:** 08/17/2006

Organization : MeritCare Health System

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

Dear Colleagues,

I cannot endorse enough the proposed changes to E/M coding reimbursement by changing the conversion factor for the more 'cognitive' specialties and primary care. The increasing grotesque disparity for reimbursement between 'procedural' and 'cognitive' specialties has led to a flight of physicians entering primary care or specialties without procedures (such as infectious diseases, endocrine, etc.). In my institution 15 years ago, the difference between the highest paid physician and lowest paid was about a 1.5-2 fold difference. Now we see this to be an 8-10 fold difference. We now find great difficulty in filling primary care positions or hiring specialists in rheumatology, infectious diseases, nephrology, or endocrinology. We see nearly all of our internal medicine residents trying to pursue fellowships in the more lucrative procedural specialties of cardiology or GI. Very few of our medical students wish to pursue residencies in primary care. I wholeheartedly agree with the ACP position paper on this very topic, that the disparity among the medical specialties is leading to an impending health care crisis for access to primary care practitioners and cognitive specialists who rely primarily on E/M coding for their livelihood. My only criticism is that these proposed changes are long overdue, and do not go nearly far enough in scope.

Sincerely,
Paul J. Carson, MD
Fargo, ND

Submitter : **Date: 08/17/2006**

Organization :

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

I am a solo practitioner who has provided mental health and substance abuse services to Medicare covered clients for the last 6 years. I work hard to be a responsible provider, so I purchase assessments and other resources to better support my clients. I provide a comfortable office in an effort to validate my client's integrity. I work hard to stay current on the lastest developments in the field of mental health and substance abuse which means going to workshops thus not taking clients on those days, a double-wammy.

In learning of these new cuts being considered, I feel abandoned, diminished, marginalized, and, my sense is that these are the prevailing feelings of those who are forced by such measures to be treated by less competent, increasingly overwhelmed agencies that remain after providers like myself are no longer able to make ends meet in the income verses expenses equation.

I am well respected in my profession and in my community. I live a modest life with my spouse and daughter. My spouse also works. I pay for a home every month. We drive 6 and 10 year old vehicles. In many cases, even with those who are utilizing Medicare benefits, my clients live way more extravagantly than I do-maybe its all on credit? I experiencing a lot of satisfaction in what I do and will likely be a service provider until I can't perform those responsibilities anymore.

One thing I am quite comfortable in believing is that the kinds of actions that your agency is getting ready to take are not moving our society in the direction of sustainability. In my view, this is another blunder that will further serve to undermine the public's confidence in our institutions. In my view, these are the kinds of actions that ultimately lead to a correction of deplorable proportions in which no one will win-that includes our federal government in whatever actions it choses to take in response to the fall-out of such decisions. In my business, we work in the support of client's realizing win-win results.

No policy, no religion, no government, no organization has a chance of long-term sustainability if it forgets what it is founded in/on-the people. Money, property, power, and prestige accomplish only short-term benefits, but, in my knowledge, none of these has every stood the test of time. Only the people and their resilience stand that test.

These decisions that are about to be made by your agency do not stike me as people oriented, thus further erosion of the publics faith will be the result, and, in my view, looking at the bigger picture, will end in chaos. In my experience, per history, the government will then need to respond with force, and, well, history keeps repeating itself.

I would like for our nation to be different, one that turns he corner and ultimately defies history. That begins, in my view, really, to place people first. This does not have to remain a dream. It has all the potential and resource to make it a reality. This is not about money, because we've got plenty of that. In my view, it is about the way that it is appropriated.

For the aforementioned reasons:

I am requesting that you, CMS, do not reduce work values by 7 % for clinical social workers effective January 1, 2007;

I am requesting that CMS withdraw the proposed increase in evaluation and management codes until it has the funds to increase reimbursement for all Medicare providers;

I request that CMS not approve the proposed Top down formula to calculate practice expense. I request that it select a formula that does not create a negative impact for mental health providers.

Thank you,

Martin J, Dressman, MSW, LSCSW, LCSW

Submitter : **Dr. David Greenfield** **Date: 08/17/2006**

Organization : **Dr. David Greenfield**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I am a solo practioner, rheumatologist. I have provided expert osteoporosis management for 21 years. I have provided on site DXA studies to my patients since 1996. The technology for DXA has advanced considerably since 96' and I have purchased the latest 'state of the art' densitometer to optimize medical care. The proposed reimbursement reduction formula utilizes outdated technical DXA methodology. Pencil beam DXA machines are less accurate and, therefore, completely useless today. In fact, I would venture to say that no one uses that archaic technology at this time. The fan beam machines are highly sophisticated and extremely accurate. This advance incurred considerable cost increases as would be expected. We have also incorporated x-ray software into the design of the machines(VDA). This allows assessment of spinal fractures without having to perform additional x-rays at another time and place. It is a convenience for the patient and also provides an important parameter to determine fracture risk. It takes more time to interpret the study but the information is invaluable. The proposed legislation to drastically reduce payment for DXA will make it impossible to continue providing this critical service to my patients. I fear that the dramatic progress we have made in identifying and treating osteoporosis over the last decade will reverse rapidly. With the onslaught of the 'baby boomers' into middle and older age, the incidence of osteoporosis could reach staggering levels. The financial and social costs would be catastrophic!!! You must REVERSE this proposed reduction in reimbursement. Sincerely, David I Greenfield, MD

Submitter : Mr. Gordon Munn **Date:** 08/17/2006

Organization : Clinical Social Worker

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

I am writing to inform you that a 14 percent decrease in reimbursement would be a detriment in my practice as a clinical social worker, my family, the economy and the care and treatment for the patient. I am strongly urging you not to implement this decrease in reimbursement as the access to mental health care is a struggle presently and if clinical social workers reimbursement is cut, there will be less providers and access and treatment would suffer. Furthermore, I ask that you not reduce work values for clinical social workers effective in January and to withdraw the proposed increase in evaluation and management as this could impact patient care in a damaging manner. Additionally, I am requesting that you do not approve the proposed "bottom up" formula to impact clinical social workers. I am aking for your consideration in these issues. Please realize what an adverse impact on clincical social workers and patients these cuts would have, not to mention job losses affecting the economy. These cuts in reimbursement are not advantageous.
Thank you for your assistance.

Submitter : **Date: 08/17/2006**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

I wish to comment on the June 29th proposed notice. It sets forth the proposed revisions to work relative value units and changes the method for calculating practice expense RVUs under the Medicare physician fee schedule. My expertise is in Physical Therapy and I have been practicing as a Physical Therapist for 30 years and in private practice for 25 years. It has been a struggle to maintain a small business with the continual increase of costs and decrease of reimbursement. Under the current law, the Sustainable Growth Rate (SGR) formula is projected to trigger a 4.6% cut in payment in 2007. Similar cuts are forecasted to continue and these cuts would be further increased by the budget neutrality adjuster proposed in the 5-year review rule that would impose additional cuts on top of the SGR. It is unreasonable to propose policies that escalate cuts on top of cuts. As a Physical Therapist, I cannot bill for the E/M service and will not derive benefits from increased payment of the E/M service. I spend a considerable amount of hands-on time with my patients in performing evaluation and treatment and this time is being reduced in value. These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment of thse services is severely cut, access to care for many of the elderly and disabled will be in jeopardy. I would like to ask CMS to ensure that severe Medicare payment cuts for the physical therapist does not occur in 2007. I would ask Medicare to acknowledge the value of physical therapy services under this payment policy. CMS might consider transitioning the changes to the work value units (RVU) over a four year period to ensure that patients continue to have access to valuable health care services. Thank you for consideration of my comments.

Submitter : **Date: 08/17/2006**

Organization :

Category : **Social Worker**

Issue Areas/Comments

Other Issues

Other Issues

CMS has released a proposal to reduce Medicare reimbursement to mental health providers by 14%. DO NOT reduce Medicare reimbursement. This proposal would force me to withdrawal as a Medicare provider to render psychotherapy, counseling, already at at a reduced rate, to all Medicare, Medicare-Medicaid members which would negatively impact these members.

Please withdraw the proposed increase in evaluation and management codes until funds are available to increase reimbursement for Medicare providers.

Please withdraw this proposed plan immediately and DO NOT approve the proposed "Top Down" formula to calculate practice expense. Instead, please use a formula that does not create a negative impact for mental health providers.

Submitter : **Ms. Amelia Bradley** **Date: 08/17/2006**

Organization : **Community Mental Health Consultants**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

In my practice, those who receive medicare benefits, are the ones most in need of mental health treatment. I treat many people now who are unable to meet their entire co-pay and are given a reduced cost, however if the base fee is reduced any this will be very difficult to continue doing what I can to treat the population most in need. It is my recommendation that all Medicare recipients at or below 200% of the poverty level qualify for QMB in order to meet their co-pay without having to determine whether eating or mental health is their priority.

Sincerely,

Amelia "Amy" G. Bradley, MSW, LCSW

Submitter : Ms. Terry Chianello **Date:** 08/17/2006

Organization : St. Charles Medical Center

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

The proposed cut for mental health providers would be devastating especially in our rural area where there are only 5 or so LCSW's who are currently willing to receive low payment from Medicare for counseling sessions. Additionally, those clients we see are very often complicated with a multiple issues and are time consuming beyond what Medicare reimburses. The proposed cut will no doubt eliminate all providers in this area to see Medicare clients for counseling. At least wait until other appropriate strategies are considered.

Submitter : Ms. Nellie Vallarta-Ast **Date:** 08/17/2006

Organization : ISCD

Category : Hospital

Issue Areas/Comments

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

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

When first starting DXA scans at Middleton VAMC, Madison, Wisconsin, in 1996 we found that 85% of the men that were referred for bone mass measurement had low bone density and would benefit from medical intervention. Over the last 10 years we have seen bone preservation and rebuilding in many individuals.

We have started VFA scanning and have found a number of previously unknown vertebral fractures. A history of one fracture puts you at greater risk for future fracture (Kanis JA, Johnell O, De-Laet C, Johansson H, Oden A, Delmas P, Eisman J, Fujiwara S, Garnero P, Kroger H, McCloskey EV, Mellstrom D, Melton Lt, Pols H, Reeve J, Silman A, Tenenhouse A.A meta-analysis of previous fracture and subsequent fracture. Bone. 2004 Aug:35(2):375-82) suggesting that medical intervention would be beneficial and cost effective.

Even though osteoporosis is dubbed the silent disease , there is pain associated with the disease in many individuals reducing their quality of life. (Lips P, van Schoor NM. Quality of life in patients with osteoporosis. Osteoporos Int. 2005 May; 16(5):447-55).
Because of the pain these individuals eliminate exercise and confine themselves in their homes. This in turn can have a social along with a medical detriment to their lives,snowballing into a huge reduction of quality in their lives.

Having the capasity to provide DXA and VFA, allow the primary care providers an additional tool to better manage their patient's health. For those individuals who are not 100% disabled, the VA recovers funding for patient's care through insurance and Medicare. For those who are not 100% disabled and have co-pay for the services, many are reluctant to have testing or take already prescribed medications due to their limited income. If the proposed reimbursement costs are passed, I can only see the situation increasing. This as a great disservice to not only our veterans who have put their lives on the line for their country, but to the general public.

The largest part of our population, the baby boomers, is now coming of age to be considered at risk for osteoporosis. Many people have not been in the practice of saving, and therefore will be very selective of the medical care they have to pay for. If congress cannot see the impact of osteoporosis, this view will be passed down to the general public. Assuming 5% inflation and the growing number of hip fractures, the total annual cost of these injuries is projected to reach $240 billion by the year 2040 (Cummings SR, Rubin SM, Black D. The future of hip fractures in the United States. Clinical Orthopaedics and Related Research 1990;252:163-6).
With testing for osteoporosis this monetary impact on individuals can greatly be reduced. DXA and VFA scans are one of the least expensive medical tests available, but can make the largest alterations to one s future.
Reimbursement costs are based on all charges needed to provide the service and it has been brought to my attention these costs have been erroneously underestimated. The majority of DXA equipment being used and for sale is the fan beam instrument. The cost of this machine is approximately $85,000 and not the older technology and lesser expensive pencil beam unit at $41,000. This is a huge error in budgeting in any profession. There is no other radiology equipment that can be purchased at the cost of $85,000 and provide such a service to a patient s health.
It is not only important to purchase the equipment, but it also must be operating in optimal condition. This requires daily QA with phantoms scan acquisition, without such true assessment cannot be made and small inconsistency can go undetected. Furthermore, this impacts the diagnosis and follow-up scans that monitor changes in bone mass. Thus phantoms should be included as part of the purchase.
With DXA units, low bone mass can be diagnosed, altered and improve quality of life, thus allowing other radiology services to focus on the critically ill.

Submitter : Ms. Alicia Galper **Date:** 08/17/2006

Organization : Ms. Alicia Galper

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

A reduction of 14% of payment for fees for medicare clients will impact services for medicare clients and the ability to give them what they need. It may make it more difficult to assist as many medicare clients versus private pay or those with other insurance. Please reconsider this payment reduction.

Submitter : Mr. Paul Timmerman **Date:** 08/17/2006

Organization : New West Physicians

Category : Physician

Issue Areas/Comments

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

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

New West Physicians currently operates a Dexa practice that serves approximately 150 patients a month. This practice would be severely impacted by the proposed reduction of CPT 76075 within 1512-PN. By reducing the Non-Facility RVU from 3.20 in 2006 to .67 in 2007; it will reduce reimbursement by over $100 per procedure, or by 73%. This reduction in reimbursement may cause New West to have to shut down the Dexa Practice in the future due to economic reasons.
The Dexa practice offers convenience, quality, and effective treatment for our patients. It would be unfortunate if we had to shut down the Dexa program due to a drastic cut in the reimbursement.

Submitter : **Mrs. martha flore** **Date: 08/17/2006**

Organization : **ingalls memorial hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Your proposed changes for reimbursement of the DXA exam for bone density loss will have a negative impact on women's health. The reductions for reimbursment will make this exam become extinct. The technology and the data base that have been procured over the past several years, will have become fruitless. Please consider the strides that have been made in this technology.

Submitter : Dr. Jay Schorr **Date:** 08/17/2006

Organization : Dr. Jay Schorr

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I bill Medicare about 20 times per month for CPT code 93701. If I am successful at collecting the full amount, this gives me about $880 in revenue. My equipment lease for the BioZ device is $860 per month. So the $20 difference must pay the tech to perform all the tests, the $13 pads that must be used for each test, and my payment to interpret the test? Please do not tell me with a straight face this is correct. Please make the necessary corrections and use appropriate equipment, disposable, and labor inputs forthis test code.

Submitter : Mr. Bob Verkler **Date:** 08/17/2006

Organization : Ingalls Memorial Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

YOUR PROPOSED CHANGES FOR REIMBURSEMENT OF THE DXA EXAM FOR BONE DENSITY LOSS WILL HAVE A NEGATIVE IMPACT ON WOMENS HEALTH. THE REDUCTIONS FOR REIMBURSEMENT WILL MAKE THIS EXAM BECOME EXTINCT. THE TECHNOLOGY AND THE DATA BASE THAT HAVE BEEN PROCURED OVER THE PAST SEVERAL YEARS, WILL HAVE BECOME FRUITLESS. PLEASE CONSIDER THE STRIDES THAT HAVE BEEN MADE IN THIS TECHNOLOGY.

Submitter : Ms. KAREN ELY **Date:** 08/17/2006

Organization : INGALLS MEMORIAL HOSPITAL

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Your proposed changes for reimbursement of the DXA exam for bone density loss will have a negative impact on womens health. The reductions for reimbursement will make this exam become extinct. The technology and the data base that have been procured over the past several years, will have become fruitless. Please consider the strides that have been made in this technology.

Submitter : **Date: 08/17/2006**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

I am concerned after reading the proposed five year review. I feel this will greatly jeapordize the availability of care for our Medicare patients. Already we see physician groups who decline to see patients who have Medicare as thier primary insurance. In my clinic if this proposed plan does go into effect, we will also discontinue seeing Medicare patients. Where then will these patients be seen.
Please look furthur into this issue and find another way to make the Medicare program survive.

Thanks,
Kristen D. MS, PT

CMS-1512-PN-1672-Attach-1.TXT

Attach #
1672

Subject: Proposed five year review regulations

To whom it may concern,

I am writing as a concerned Physical Therapy practitioner. I have recently read the proposed five year review and am worried that this will greatly change the way Medicare patients are treated within our healthcare system. Already we see physician groups who don't take patients who have Medicare as their primary insurance. Physical Therapy is also heading this direction. I know the clinic where I work will discontinue treating our Medicare patients because of low reimbursement rates. Where will Medicare patients be seen then? Are you really concerned about their well-being?

Please spend some more time looking over the issues. Let's try to find another way to save the Medicare program.

Sincerely,

Kristen D. MS, PT
Zip code 98685

Submitter : Dr. Paul Radensky **Date:** 08/17/2006

Organization : McDermott, Will & Emery, LLP

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1673-Attach-1.PDF

1673

August 16, 2006

Via electronic submission at http://www.cms.hhs.gov/eRulemaking
Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

RE: CMS–1512–PN
Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology
Payment for home PT/INR monitoring (codes G0248, G0249, and G0250)

Dear Dr. McClellan:

On behalf of the Prothrombin-time Self Testing (PST) Coalition comprising HemoSense, Inc., International Technidyne Corporation and Roche Diagnostics Corporation, we are pleased to submit comments on the above-captioned Proposed Notice regarding Prothrombin Time (PT)/International Normalized Ratio (INR) home monitoring for anticoagulation management. The PST Companies are medical device manufacturers who have developed the technologies used in home PT/INR monitoring. Our companies have put significant resources into the clinical development of these technologies, which have been shown to reduce the incidence of serious adverse events (strokes and bleeding) among patients requiring anticoagulation with warfarin.

We appreciate Medicare's having provided coverage for home PT/INR monitoring beginning July 2002, and we were pleased to see clarifications on billing for these services published in several Program Transmittals and codified in the Medicare Claims Processing Manual, Chapter 32, Section 60. Medicare's allowed payments for home PT/INR monitoring under the Physician Fee Schedule in 2006 are adequate to cover physician and Independent Diagnostic Testing Facility (IDTF) costs for furnishing home PT/INR monitoring equipment, supplies, clinical staff support and physician interpretation and reporting of results.

By contrast, the Proposed Notice would result in reductions in payments for the training and technical component services of home PT/INR monitoring by approximately 40 to 50-percent over the next 4 years (codes G0248 and G0249). These reductions, if implemented, would result in payments well below physician and IDTF costs for furnishing home PT/INR monitoring and would likely shut down access to home PT/INR monitoring for Medicare beneficiaries. It appears the reductions are caused by application of the new practice expense methodology without considering that the current practice expense relative values for G0248 and G0249 were developed by CMS staff as an exception to the current practice expense methodology. Maintaining the "hard coded" practice expense values would assure fair payment for home PT/INR monitoring services and continued access to the technology for Medicare beneficiaries.

Coding and Practice Expense Inputs for Home PT/INR Monitoring

Home PT/INR monitoring involves the furnishing, by a physician or IDTF, of a PT/INR monitor (a prothrombin time test meter), test strips to run in the monitor, lancets for collecting blood samples, and alcohol swabs for preparing the skin for the self-testing of prothrombin time by patients or their

caregivers at home (or otherwise outside the physician's office setting) on a weekly basis[1]. Home PT/INR monitoring is reported under the following three HCPCS codes to include the technical component service described above as well as an initial training session and physician review and interpretation of the test results:

Code	Descriptor	Equipment*	Supplies*	Clinical staff*
G0248	Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing	Home INR monitor (50 min use)	INR test strips (4); lancets (4); batteries (3); alcohol swab pads (4); patient education booklet	RN/LPN/MTA (75 min total)
G0249	Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; per 4 tests	Home INR monitor (20 min use)	INR test strips (4); lancets (4); alcohol swab pads (4)	RN/LPN/MTA (13 min total)
G0250	Physician review, interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service)	None	None	Zero labor

* From the 2006 Final Rule Practice Expense Inputs.mdb

[1] The coverage policy limits coverage to testing no more than once per-week. The 4-test payment units under codes G0249 and G0250 may reflect weekly testing over a 4 week period or less frequent testing over a longer period.

Concern about the Practice Expense Relative Values in the Proposed Notice

Home PT/INR monitoring is an unusual service under the Physician Fee Schedule because it involves the furnishing of equipment and supplies by physicians or IDTFs for use by patients in their homes. Each PT/INR monitor is dedicated for use by one patient only. Therefore, although the practice expense input files show the monitor to be in use for only 20 minutes for each 4-test payment unit under code G0249, the monitors are effectively in use continuously by each patient. CMS staff recognized this when the practice expense relative values for home PT/INR monitoring were initially developed. The staff acknowledged that the "standard" model for assigning per-minute input costs for equipment should not be used for home PT/INR monitoring. The practice expense equipment model assumes that equipment can be used by multiple patients for up to 25 hours per-week. This assumption does not apply to home PT/INR monitoring. Therefore, staff did not apply the standard practice expense model, but rather, applied the equipment costs by considering a straight line amortization over the useful life of the meter.[2]

We are concerned that this exception to the standard practice expense input cost model was not recognized when the values were established for the Proposed Notice. Unless this exception is "hard coded" into the system and maintained with the proposed changes in the practice expense methodology, payments for home PT/INR monitoring will be cut in half, which will significantly limit access to this important technology.

When we met with staff from the Hospital and Ambulatory Policy Group in 2002 following the release of the coverage decision memorandum and prior to release of the implementing instructions, we expressed serious concern about access to home PT/INR monitoring by Medicare beneficiaries if the benefit were structured as a physic ian or diagnostic testing service paid under the Physician Fee Schedule. CMS staff assured us that they would monitor access to this new technology and would make changes to the payment policies to assure appropriate patient access. Current levels of payment under the Physician Fee Schedule appear adequate to support access to this technology. The practice expense values in the Proposed Notice, however, would result in payments that likely would shut down access to this service by Medicare beneficiaries.

Recommendation

Therefore, we urge CMS to maintain the current practice expenses for home PT/INR monitoring under codes G0248 and G0249 consistent with the values that were "hard coded" into the payment system since late 2002.[3]

* * * *

[2] Through 2004, the equipment was assigned a price of $2,000 and a useful life of 4 years. In the 2005 and 2006 practice expense input databases, the equipment was assigned a price of $2,000 and a useful life of 5 years.
[3] We would note that the payments for the professional service fee for review and interpretation of the PT/INR results (code G0250) do not include direct practice expenses and so are not negatively affected by the proposed change in practice expense methodology.

We appreciate the opportunity to comment on this Proposed Notice. Please contact our reimbursement counsel, Paul Radensky, M.D., J.D., at 305.347.6557 or by e-mail at pradensky@mwe.com if you have any questions about our comments or would like to discuss these further. Thank you for your consideration of our comments.

Sincerely,

/s/ Larry Cohen

Larry Cohen
President
International Technidyne Corporation

/s/ David Phillips

David Phillips
Vice President, Marketing
HemoSense, Inc.

/s/ John Ridge

John Ridge
Director, Reimbursement Affairs
Roche Diagnostics Corporation

Cc: Paul Radensky, M.D., J.D., McDermott, Will & Emery LLP

Submitter : **Ms. Deb Howard** **Date: 08/17/2006**

Organization : **E Tx Infectious Disease Consultants, PLLC**

Category : **Individual**

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.

GENERAL

GENERAL

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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. Karen Boland **Date:** 08/17/2006

Organization : ASA

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

In the Federal register of June 29, the new CMS practice expense methodology & changes in work values unfairly hurts anesthesiology more than most specialities 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 before making any changes. In addition, it is not fair for anesthesiologists and other specialities to have huge payment cuts to supplement the overhead cost of a handful of specialties. Last, the CMS must address the issue of anesthesia work undervaluation or our nation's most vulnerable populations will face a certain shortage of anethesia care in operating rooms, pain clinics, and throughout critical care medicine.

Submitter : Mrs. Joyce Cunningham **Date:** 08/17/2006

Organization : Center for Clinical Social Work

Category : Health Care Professional or Association

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

Please see attachment

CMS-1512-PN-1676-Attach-1.PDF

HHaCrA
1676

August 14, 2006

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

Re: CMS-1512-PN – General Comments

To Whom It May Concern:

I am writing from the Center for Clinical Social Work, on behalf of the nation's tens of thousands of clinical social workers, regarding CMS-1512-PN and its effect on healthcare delivery and the practice of clinical social work. Clinical social workers provide the bulk of mental-emotional health services in the United States and are essential to the functioning of a comprehensive healthcare delivery system. Despite their high standing as professionals, their fees have generally remained constant or even declined since 1997, while clinician costs have increased in line with the general cost of living.

Medicare is a major beneficiary of the clinical social workers' efficacy and reasonable fees for professional services: the Medicare system's long-term costs are greatly reduced by the efficient use of clinical social work services, under which more preventive and primary mental healthcare is provided at lower cost to more clients. Clinical social workers are already being paid a low fee in relation to physicians and psychologists, per the current CMS schedule, especially given that many of the services provided are identical or superior to those of the other professionals. To use a "bottom up" formula to calculate practice expenses of those already practicing efficiently—and to expect clinical social workers to accept another 14% decrease in reimbursement by 2010—is unfair and arbitrary. Clinical social workers already carry the burden of mental-emotional health delivery at the lowest cost; and the managed-care enterprise may well interpret this proposed decrease as a signal to reduce their own reimbursement rates for clinical social workers. To lower their fees further only serves to discourage their participation and ultimately to cost the system more in higher costs for more expensive care.

We strongly urge CMS to alter your proposal and to appreciate that, by education, training, and experience, clinical social workers are professionals deserving of a fair rate for the services they provide. The CMS proposal increases the reimbursement rates for physicians, at the expense of all others, including those in need of treatment. Please reconsider, and reformulate your proposal to treat all Medicare providers in a more uniform and fair manner.

Sincerely,

Joyce Cunningham, MSW, BCD
President, Board of Directors
The Center for Clinical Social Work
Shetland park
27 Congress St. #211
Salem, MA 01970

Submitter : **Warren Hathaway** **Date: 08/17/2006**

Organization : **Warren Hathaway**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am requesting CMS NOT reduce work values for clinical social workers effective January 1, 2007. Clinical social workers like myself who provide services to medicare eligible clients are already struggling to maintain their practices. This proposal will drive many more from the profession or cause them to significantly limit the medicare clients they are willing to treat.

I would request CMS withdraw the proposed increase in evaluation and management codes until CMS is able to increase reimbursement for all Medicare providers.

Additionally, CMS should not approve the proposed 'bottom up' formula to calculate practice expense. This bottom up proposal would have a negative impact on social workers who experience limited practice expense.

The bottom line is the effect of this proposal will be to significantly decrease the clinical social work services to our medicare recipients. This will ultimately drive up costs as more expensive treatments and services (inpatient hospitalizations, etc) become necessary as a result. Negatively impacting such a large provider group (clinical social workers) is bad policy because its impact on services will be equally negative and large.

Good public policy is cost effective. This is not good public policy and nor will it be cost effective in the longer term.

Thank you,

Warren Hathaway, MSW, LICSW
Plainfield, VT

Submitter : **Date: 08/17/2006**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

I am a Physical Therapist Assistant working at a small private outpatient clinic in a rural area of Virginia. A large percentage of our caseload are Medicare patients and the payment cuts Medicare is proposing will greatly affect the services that we will be able to provide for this growing population. Many of these patients have multiple diagnoses and our care will be limited if Medicare continues on this course of cutting payments. Thank you for your time in reading these comments and I hope Medicare will reconsider its course of action.

Submitter : Mrs. JANA SCHNEIDER **Date:** 08/17/2006

Organization : Marshfield Clinic, Indianhead 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

Im am gravely concerned about the proposed cuts for dual energy xray absorptionmetry and vertebral fracture assessment.. These cuts have been proposed as part of a new 5 year review of the Mediacare Physicians Fee Schedule. If these cuts are not reversed, in 2010 they would abount to a decline in payment of 71% for DXA and 37% for VFA. It is my opinion that this action will severly reduce the availability of high quality bone mass measurement, having a profound adverse impact on patient access to appropriate skeletal healthcare. Wouldn't it be more monetary sound to be proactive, providing bone analysis with subsequent treatment rather than incurring the huge costs for care when fractures occur?
I am asking that the proposed cuts can be reversed so that our aging population can preserve a quality of life by minimizing the the significant societal costs associated this bone fractures.

Most sincerely yours,
Jana Schneider RTR CDT

Submitter : **Dr. Peter Giebeig** **Date: 08/17/2006**

Organization : **Giebeig Family Medicine, PA**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

To whom it may concern:

I am a relatively young physician (36 years old), who practices in a growing market. There are several issues which will negatively impact my practice. My practice consists of two provider, myself and a nurse practitioner. We provide superb preventive medical care as well as hospital care and limited outpatient testing (bone density and clia-waived lab).

Our patients have been extremely satisfied with their care; however, due to cost constraints (rising practice costs, ex. utilities, salaries, supply costs), we are finding very little room to make ens meet. Further limiting reimbursement would restrict our ability to practice medicine and may eventually drive us out of medicine entirely. Our patients should be provided access to common outpatient medical tests, such as bone density testing. Cutting reimbursement would likely result in our discontinuing this available test.

My patient base is made up largely of geriatrics. Since I do not round in nursing homes, many of these of high functioning elderly individuals. It is not uncommon to see everyone on my schedule be at least 75-95 years old. Consequently, these patients have more issues and ailments that a routine population. It stands to reason that reimbursement take these facts into account.

In the North Florida area, we project the need for 17 additional primary care physicians in the next 5-10 years. This need is compounded by the problem with reimbursement, especially in the areas of provider recruitment and retention. This severely affects patient's access.

I would hope that you will take these issues into strong consideration before any measures are taken to further limit reimbursement. In the United States, we have long had the world's best healthcare system; however, that is in a great deal of jeopardy unless reimbursement issues are handled properly.

Thank you for you time.

Sincerely,

Peter Giebeig, MD

Submitter : **Dr. Jerry Sheen** **Date: 08/17/2006**

Organization : **ID Care**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

E/M service codes with Relative Value Unit recommendations is definitely a more fare way to reimburse non-surgical specialties and ultimately improve patient care.

Submitter : Mrs. Patti Ranieri **Date:** 08/17/2006

Organization : Northern Westchester Putnam Physical Therapy, PC.

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

I am a physical therapist, and have been practicing for 4 years. At this time I am employed at a private practice in Westchester County, NY.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 RVU's under Medicare physician fee schedule.I am urging CMS to ensure that these severe Medicare payment cuts for PT's and other health care professionals do not occur in 2007. CMS should transition the changes to work RVU's over a 4 year period to ensure that patients continue to have access to valuable health care services. Under current law, the "substantial growth rate" formula is projected to trigger a 4.6%cut in payments in 2007. Similar cuts are forecast un until 2015. It is unreasonable to propose a policy that piles cuts on top of cuts. PT's cannot bill for E/M codes and will derive no benefit from increased payment. Therfore, 2007 will be a devastating year for PT's. These proposed cuts will undermine the goal of achievig a greater quality of care, as well preserving patient access. The care for millions of elders will be jeopardized if these services are cut so severly. Our patients are very important to us, and the thought that we will not be able to spend the valuable time needed to help them is very daunting. The face to face consultation and treatment of these patients is being devalued.
Thank you very much for considering these comments.
Sincerely, Patti Ranieri, MSPT

Submitter : **Jenifer Osko** **Date: 08/17/2006**

Organization : **Breast Diagnostic Center**

Category : **Other Technician**

Issue Areas/Comments

Practice Expense

Practice Expense

I am writing in opposition to the proposed changes to the Medicare Physician Fee Schedule (CMS-1512-PN, RIN 0938-A012.) The change in global reimbursement for DXA (CPT 76075) from $140.00 to $38.00 would not cover our technical costs in performing this service to our patients. Our technical costs include the cost of the unit, yearly preventive maintenance and upkeep, supplies, technical wages and radiologist time; all of these make the proposed reduction in reimbursement unreasonable. We have a Hologic Delphi unit that uses a fan-beam, NOT a pencil-beam technology that was used for your review, this higher technology needs to be taken into consideration.
Our patient care is the utmost of importance to our practice. By allowing the reduction in reimbursement our patient care would be compromised and would have a negative impact on women's access to this important test.
Please take time to reconsider these proposed changes to allow all facilities to continue with quality patient care that we all deserve.

Thank You,
Jenifer Osko, RT (R)(M)(CDT)
Director of Imaging
Breast Diagnostic Center

Submitter : Mrs. debb nygaard **Date:** 08/17/2006

Organization : Breast Diagnostic Center

Category : Individual

Issue Areas/Comments

Practice Expense

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Please take time to reconsider these proposed changes to allow all facilities to continue with the quality patient care that we all deserve.

Submitter : Mr. George Roman **Date:** 08/17/2006

Organization : American Medical Group Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached comments letter.

CMS-1512-PN-1685-Attach-1.DOC

Attach #
1685

AMGA
American Medical Group Association

August 17, 2006

Mark B. McClellan, MD, PhD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014, 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:

AMGA is an association that represents medical groups, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA members' 65,000 physicians deliver health care to more than 50 million patients in 40 states, including 15 million capitated lives. Thank you for the opportunity to comment on the Five Year Review and Practice Expense (PE) proposed rule.

Valuation of Dual Energy X-ray Absorptiomerty Based on Incorrect Assumptions

Since there are CPT codes in the Five-Year Review that gain and lose value, and the average size of our member organizations is 273 physicians, including virtually all medical specialties, the impact of the various changes in specific, proposed CPT code values is difficult to assess in the aggregate. We will therefore leave comments on specific CPT codes of the Five-Year Review of work values to the specialty societies, save one code: Dual energy X-ray absorptiometry (DXA; CPT code 76075).

DXA and vertebral fracture assessment (VFA; CPT code 76077) testing is pivotal in the evaluation and management of patients with suspected osteoporosis. This malady is high in the hierarchy of national public health policy initiatives with the objective of reducing the personal and societal costs of osteoporosis.

Some of the elements and suppositions used to compute the Medicare Physician Fee Schedule were not correct: The technical component was tallied using pencil beam instrumentation with a price of $41,000 instead of the $85,000 assigned to VFA, which is done on fan beam densitometers. However fan beam instrumentation is what is used in the overwhelming majority of densitometers in doctors' practices today. Hence a more realistic equipment cost component for DXA would have been $85,000. Secondly, equipment rate utilization assigned to DXA is shown as 50%, the number used for all diagnostic imaging equipment. Given the typical and predominant site of service of DXA and VFA, a more likely utilization rate would be an estimate of 15-20%.

Furthermore, some practice expenses for densitometry such as phantoms[1], necessary service contracts/software upgrades and office upgrades to allow electronic image transmission capability, were not counted at all, thus not rendering the full cost picture.

Finally, we believe to be erroneous the conclusions of the AMA Relative Value Update Committee (RUC) that DXA interpretation is less intense and more mechanical than the suggested work value of .2 represents This finding does not properly take into account that high quality DXA reporting requires skilled interpretation of the multiple results the equipment generates.

At the conclusion of the phase-in period in 2010, reductions of reimbursements for this test would amount to 71% for DXA. Since 70% of this testing is done in physicians' offices, we are concerned that the consequences of drastic cuts will make offering DXA economically unfeasible. This may reduce Medicare patient access to these important diagnostic tests and have a profound adverse effect on patient care for osteoporosis. **We therefore ask CMS to revert to the specialty society survey recommendation and restore the work value to .3 from the proposed .2 units.**

Budget Neutrality Adjustment and "Bottom-Up" Methodology—Other Issues

CMS proposes a budget neutrality adjustment to the work RVUs, having noted that it considered but rejected the alternative adjustment to the conversion factor, an approach. CMS has used in past five-year reviews. The rationale for this was the putative origin of the impacts as coming largely from the work unit changes. However, AMGA believes changes in work RVUs and the practice expense methodology are inexorably linked. Attributing overall changes to one over the other is not a compelling reason to deviate from past practice. This conclusion is heightened by the fact that the proposed work adjustor would appreciably diminish proposed payment increases for evaluation and management services. Therefore, we recommend that CMS reconsider and opt to apply the budget neutrality adjustment by changing the conversion factor as it had originally contemplated.

AMGA has gone on record as supporting a more transparent, accurate, and simplified system of deriving relative value units and their components. **The proposed shift to a "bottom-up" computation is a step in the right direction, and we support this move.**

Multi-specialty Practice Expense Survey

AMGA believes that the basis CMS used for determining medical practice expenses, the AMA's defunct Socioeconomic Monitoring System (SMS) is beyond antiquated.

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[1] This is an X-ray image of a plastic block (phantom) used to simulate radiographic characteristics of breast tissue, used to assess the ability of the equipment to detect breast disease and cancer. For full facility accreditation such images are mandatory and must be submitted to the accrediting body.

Constant adjustments and recalibration of these numbers has made accuracy of derived information questionable for years. It should have been supplanted long ago by a new, multi-specialty practice expense survey and we support implantation of such an instrument.

The "public-private partnership" between CMS and elements of organized medicine, has been successful in many ways. Using the good offices of national medical organizations as the means for obtaining and distributing practice expense data is both practical and effective. We believe that the division of responsibilities has been unbalanced with organized medicine having made invaluable in-kind as well as real financial cost contributions. CMS has not borne its fair share.

We support CMS' reliance on specialty societies and other medical organizations for data gathering since we feel the response rates and quality of information, gathered on a voluntary basis, through their good offices, yields results that are, in most cases, statistically powerful and reliable. Since the gathering of such data serves a broad public health policy objective, pricing of physician services for Medicare, we feel that the financial burden should be paid by the government. **We call on CMS to fully fund and implement at the earliest opportunity, a multi-specialty practice expense survey, and there is one such effort by the American Medical Association (AMA) already well underway.**

The extant, emerging multi-specialty survey, whether eventually adopted or supplanted by another, similar CMS effort, raises important questions regarding CMS' announced intention to allow supplemental PE survey data submitted by several medical societies. Specialties which have conducted supplemental surveys will argue that their data should be implemented and utilized until new data from a multi-specialty practice expense survey are available. Others will call on CMS to refrain from any further practice expense methodological changes until data from a multi-specialty practice expense are available.

We suggest a conditional approach to deciding on use of the supplemental surveys. If CMS intends to use the current multi-specialty PE survey effort or one of its own creation in the practicably near future, then AMGA suggests that holding in abeyance the use of supplemental data is a preferable course of action. To change PE values now and then perhaps have to readjust many work values considerably (CMS noted that some have suggested that the supplemental surveys have inflated PE) based on new, more reliable data, makes for too much potential dislocation and uncertainty for medical practices' planning and forecasting needs. If, on the other hand, CMS foresees no realization of a multi-specialty PE survey in a reasonable time, the supplemental data should be accepted.

Discussion of Comments—Evaluation and Management Services

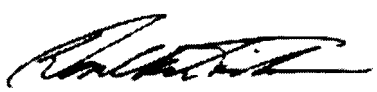
The findings and analyses of the RUC address inaccuracies and correct them. **We agree with CMS' conclusions and AMGA supports the proposed valuations for Evaluation and Management Services (E/M) and endorses their implementation.**

Transition of the Changes

Medical group practices are facing a difficult year in 2007 with the pending physician fee schedule negative updates, anticipated reductions in payments to imaging services resulting from the Deficit Reduction Act (DRA), and the difficult to predict consequences of the five-year review and PE methodology changes. **Phasing in the changes over a four year period as proposed in the rule will ameliorate the negative effects of these combined changes and we support such a transition.**

AMGA appreciates the opportunity to offer its perspectives for CMS' consideration. Any questions about our comments should be directed to George Roman, Director, Regulatory Affairs, at (703) 838-0033, extension 342.

Sincerely,



Donald W. Fisher, Ph.D.
President and CEO

Submitter : Dr. James David **Date:** 08/17/2006

Organization : James R. David, Ph.D.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1686-Attach-1.DOC

Attachment 1686

JAMES R. DAVID, Ph.D.

CORPORATE PEOPLEMAP™ TRAINING, PERSONAL & BUSINESS COACHING,
INDIVIDUAL & COUPLES PSYCHOTHERAPY
14220 BRADSHAW DRIVE, SILVER SPRING, MD 20905-6503 TELEPHONE & FAX (301)989-9155
james519@comcast.net www.askdrdavidnow.com

To: (CMS) Centers for Medicare and Medicaid Services

Subject: Proposed 14% Fee Reduction

RE: CMS-1512-PN

1. The CMS proposed 14 percent reduction of the Medicare reimbursement rate will motivate me to:
    a. Stop treating Medicare patients.
    b. Stop treating TRICARE beneficiaries because their fee schedule is 80% of the CMS fee schedule.
2. **Rationale**:
    a. CMS is obviously copying rates established by the major mental health managed care companies who routinely take 45% to 63% for overhead, profit, acquisitions, etc. (CMS overhead is 3%.)
    b. I have been a practicing clinical social worker for 32 years. I can clearly remember being paid more for an hour of psychotherapy 28 years ago than what we are now paid.
    c. A good mental health and substance abuse plan requires **competent and experienced professional providers.**
        1) Reducing private practitioner's fees is self-defeating and a false economy.
        2) Low fees will turn the profession of clinical social work into a **volunteer charity** affordable only to people subsidized by a spouse's income or an inheritance or retirement from another job.
        3) Good therapists will not accept lower fees.
        4) You will be left with the least experienced, least competent practitioners treating the most difficult cases.
        5) New people will be discouraged from coming into the field.
        6) Because the overhead expenses of a clinical social worker in private practice will remain the same, **every dollar of fee reduction will represent about two dollars less in taxable income.**
        7) Remember that as **independent contractors,** CSWs **pay their entire overhead- rent, utilities, supplies, continuing education – as well as 100% of Social Security. Any benefits they take from health care to disability insurance or retirement come out of their taxable income. CSWs also work 2 hours for every paid hour.**
            - For example, for a CSW at $90 per hour has a taxable income of about $75,000 per year.
            - At $55 per hour taxable income drops to about $30,000 per year
            - **At $45 per hour taxable income drops to about $16,000 per year**
            - Again taxable income does not include any benefits like health insurance while at the same time 100% of social security comes from that amount.
        8) With the dramatic Draconian fee cuts by Managed Care, the practice of psychotherapy has been **changed from a cottage industry to a sweatshop** where the psychotherapists are piece laborers.
        9) **The impact of these fee cuts is that client recovery rates drop dramatically, requiring additional and more expensive future treatment while the cost of comorbidity mounts on the medical side.** (Wrich, Rationale for Providing

Mental Health and Chemical Dependency Treatment Services to State of Maryland Uninsured Citizens, 2001)

d. **Comorbidity**: Morbidity means something causing a disease. Comorbidity means a disease has more than one cause.
    1) For each medical case there is a **40 to 60% chance that a behavioral health problem is an underlying factor in a physical disease.**
    2) For example, think of the impact of depression on heart disease. Think of the impact of alcoholism on diabetes. Think of the stress impact of an alcoholic spouse on the non-drinking spouse's depression or anxiety. (James T. Wrich, Brief Summary of Audit Findings of Managed Behavioral Health Care Services Submitted to the Congressional Budget Office; October 2000)
    3) A second serious problem with this division is that behavioral health problems **frequently go inappropriately treated or undiagnosed** by the Medical/Surgical component. 37% to 86% of audited managed care cases had clinical and administrative problems that were potentially jeopardizing to the patient. (Wrich, Ibid, 2000.)

e. We are **independent contractors** – we work for ourselves – like truckers, baseball players, musicians, and members of the Screen Actors Guild. Unlike them, we cannot collectively bargain at this time because **we are not exempt from anti-trust laws.** We can negotiate with CMS and managed care organizations but it is generally fruitless.

Even though Managed Care has **a monopoly on the DISTRIBUTION of our product** and sets the fees and terms under which we are allowed to practice our profession, we have not been able to negotiate any of these issues with it.

3. **Related Issues**:
    a. Equal Pay for Equal Work: All licensed therapists who do the same work should be compensated at the same level or the difference based on academic credential should be minimal. We all go to the same CHE training.
    b. All Ph.D.'s, whether in nursing, psychology, social work, marriage and the family, etc. should be paid the same.
4. **Summary**: Older citizens have more health problems with greater comorbidity incidence levels. Strengthening mental health treatment reduces medical treatment costs. Weakening mental health treatment through the proposed 14% reimbursement cut is cost ineffective. Mental Health professionals already are more severely victimized by managed care than are medical professionals. We are in an oligopoly, i.e. a market monopoly where a few producers of health services control the demand from many buyers. And we are powerless, stuck in the middle and forbidden by law to negotiate (unionize) as a group for living wage compensation.
5. **Requests**:
    a. That CMS not reduce work values by 7% for clinical social workers effective January 1, 2007;
    b. That CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and
    c. That CMS not approve the proposed "Top down" formula to calculate practice expense. Select a formula that does not create a negative impact for mental health providers.
    d. That CMS lobby the President and the Congress to move money from the DOD budget and tax breaks for millionaires so that improved funding occurs for healthcare. Also, provide Medicare for Everyone (Single Payer System) and save BILLIONS.

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