Submitter : **Mrs. Rita Schmidt** **Date: 08/17/2006**

Organization : **Mrs. Rita Schmidt**

Category : **Other Technician**

Issue Areas/Comments

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

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

How can you even consider cutting reimbursement for DXA bone densitometry? Only about 40% of eligible women get scanned and most have some degree of osteoporosis. All that a budget cut will do to this service is create many more Medicare claims for hospitalizations and nursing homes for fracture care, joint replacement, and spine surgeries. With the baby boomers coming into this scenario you are asking for trouble.

Submitter : Dr. Tracy Smith **Date:** 08/17/2006

Organization : Omni Medical Group

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

As a primary care physician, my job is to listen to the patient, come to a diagnosis and then coordinate treatment. Treatment may consist of my own advice, prescribing medications or referring to a specialist for a procedure. The amount of reimbursement for primary care's E&M services is too low. The amount of reimbursement for a specialist doing a procedure is much higher. However, doesn't it make sense to compensate the physician who spends the time necessary to make the diagnosis which necessitates a procedure? Patients need someone to talk to about their problems, not a technician whose main focus is performing a procedure, without interacting much with the patient.

Submitter : **Mr. Steve Mathis** **Date: 08/17/2006**

Organization : **Valley Imaging Partnership**

Category : **Health Care Professional or Association**

Issue Areas/Comments

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

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

On June 21st, CMS published a notice that proposes changes to the Medicare Physician Fee Schedule which includes an 80% reduction in the technical portion and a 50% reduction in the professional component for DXA of the axial skeleton. When fully implemented the global reimbursement for a DXA scan which is currently about $140 will be reduced to $38.

We believe the methodology employed by CMS has errors as to the assumptions of operating costs and utilization of DXA. There is a difference in equipment cost and maintenance between the older pencil beam and newer fan beam technology.

Our imaging center provides DXA scans to our patients as a community benefit. This service at our current reimbursement is provided at a loss. On a busy month, we occassionally break even. Declining reimbursement for DXA will impact our ability to continue to offer this service to the patients in our community.

Please take another look at the operating costs and utilization of FAN BEAM DXA Systems. Rethink the reduction for DXA of the axial skeleton. Delays in discovering osteoporosis will result in an increase of pathologic fractures at a much higher expense compared with early diagnosis of osteoporosis.

Sincerely,

Steve Mathis, COO
Valley Imaging Partnership

Submitter : Mrs. Dawn Durham-Pappas **Date:** 08/17/2006

Organization : Upper Mississippi Mental Health Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

As a clinical social worker who works for a nonprofit agency I am deeply concerned about the proposed 14% reimbursement cut for services I provide will affect my agency. I urge CMS to not reduce work values for clinical social workers effective Jan 2007. I request CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all medicare providers. Do not approve the the proposed "bottom up" formula to calculate practice expenses but instead select a formula that does not create a negative impact for clinical social workers who have little practice expense as providers. As medicare is the standard of care for many other insurers, setting this type of reimbursement precident could result in a decrease in reimbursement across the board. When are we going to expect payment for services which takes into consideration the time, expense and expertise of the professionals in the field of clinical social work. It makes one wonder if there really is a desire to serve the mentally ill!!

Submitter : **Mrs. Connie Busch** **Date: 08/17/2006**

Organization : **Trinity Health**

Category : **Other Technician**

Issue Areas/Comments

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

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

We recommend that CMS withdraw its proposed reduction for the technical component of CAD until such time that providers can differentiate between utilization of CAD with analog or digital mammography. The CPT codes for CAD with mammography (76082,76083) contain the phrase,"with or without digitization of film radiographic images.". There have been no changes to substantiate this proposed rule for the use of CAD with analog mammography.
Sincerely,
Connie Busch RT(R)(M),Lead Mammographer
Trinity Health
400 Burdick Expressway East
Minot, ND 58701

Submitter : **Mr. Richard Grounds** **Date: 08/17/2006**

Organization : **Augusta Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

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

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

To Whom it May Concern:

It's my understanding that CMS is considering the reduction of reimbursement for DXA scans based on some assumptions that may be highly inaccurate. IF your assumptions regarding equipment costs is calculated based on most facilities utilizing the "pencil-beam" technology, then that's most likely going to be in error. Most facilities these days, including our own, have long switched over to replacing this older technology with the newer, faster, more accurate, "Fan Beam" technology. This equipment is considerably more expensive and as a result the depreciation expense is much higher as well. Thus, the result is a serious underestimation of the actual costs of providing this state-of-art screening for osteoporosis which affects so many people today.

Therefore, to reduce the current reimbursement by the rates proposed(80% technical, 50% prof comp) would be unfair to most healthcare providers of this service, as well as the physicians who review the findings and render diagnoses for these procedures.

Many in the healthcare field to whom I have spoken with recently regarding this matter are all in agreement that these proposed cuts in DXA reimbursement will negatively impact women's access to this important test by forcing many institutions to discontinue providing this valuable patient-care service.

So, I plead with you to go back and recalculate the typical costs based on the more accurate and correct assumption that most facilities are utilitizing Fan Beam Technology DXA scanners. I think that as a result, you would then seriously reconsider the drastic reduction in proposed reimbursement cuts for this particular service.

Thank you for taking the time to review this and I hope it causes those in the position to do so to consider taking the appropriate action in the continued evaluation of this service.

Respectfully, Richard L. Grounds - Director for Cardiology & Radiology Services, Augusta Medical Center, Fishersville, Virginia.

Submitter : **Mrs. Jessica Johnson** **Date: 08/17/2006**

Organization : **Women's Health Center of Southern Oregon, P.C.**

Category : **Other Technician**

Issue Areas/Comments

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

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

August 17, 2006

Dear Centers for Medicare and Medicaid Services,

I am a certified, licensed DXA technician currently working in Women's Health and I am writing to express my concerns and objections regarding your proposed Medicare reimbursement for DXA scans. DXA and VFA testing is very important in the evaluation and management of patients with suspected osteoporosis.

The proposed cuts in reimbursement for DXA testing are at odds with multiple Federal initiatives to reduce the personal and societal cost of osteoporosis. The Bone Mass Measurement Act, the US Preventative Task Force recommendations and the Surgeon General's Report on Osteoporosis all underscore the importance of DXA in the prevention and treatment of osteoporosis. These Federal initiatives, coupled with the introduction of new medications for the prevention and treatment of osteoporosis have improved skeletal health and dramatically reduced osteoporosis related fractures.

Also, some of the assumptions used to recalculate the Medicare Physician Fee Schedule were inaccurate. CMS calculated the practice expense, utilizing pencil beam instrumentation at a cost of $41,000, instead of the $85,000 assigned to VFA, which is done on fan beam densitometers. Our office instrument is fan beam, as is the vast majority of densitometers currently in practice, so the equipment cost for DXA should be listed at $85,000.

In addition, the proposed reimbursement of approximately $40.00 does not even cover the cost of operation for our DXA system, and therefore will have a significant impact on patient access to osteoporosis screening with consequent decline in quality osteoporosis care. The equipment rate utilization that CMS has assigned to DXA assumes that all diagnostic equipment is in use 50% of the time, based on high volume imaging centers. However, diagnostic equipment (such as DXA and VFA) which is used to evaluate single disease states, should be expected to have lower utilization rates estimated at 15-20%.

I work very hard to provide the highest quality of patient care and prevention of disease, and this proposed reduction in reimbursement will deeply impact my ability to offer my patients the osteoporosis screening they need. The cost of the machine, the cost of the maintenance contract, the cost of qualified DXA technicians, and the cost of skilled interpretation, will result in my inability to provide this beneficial service. Without available DXA testing, the patients that I serve will pay the ultimate price: they are the ones who will go undiagnosed and untreated for osteoporosis, a very treatable disease. They are the ones who will suffer with unnecessary fractures, loss of productivity and disability. The costs to CMS ultimately will be greater as fractures, hospitalizations, medications, and disability issues arising from lack of testing and treatment for osteoporosis arise.

I sincerely urge you to reconsider your proposal to reduce reimbursement for DXA and VFA testing in the evaluation and management of patients with suspected osteoporosis.

Sincerely,

Jessica L. Johnson, Certified Bone Densitometry Technician
Women s Health Center of Southern Oregon, P.C.
700 SW Ramsey Ave, Suite 101
Grants Pass, Oregon 97527
(541) 479-8363

Submitter : Dr. Susan Chambers **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1694-Attach-1.DOC

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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

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

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

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

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

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

Importantly, it appears that some of the assumptions used to recalculate the Medicare Physician Fee Schedule were inaccurate. For example, CMS calculated the equipment cost at less than half of what it should be, because they based it on older pencil beam technology that is now infrequently used. They also calculated the utilization rate for this equipment at a falsely high rate that does not reflect the average use of equipment used to evaluate single disease states. Rather than the 50% rate assigned, DXA and VFA

equipment utilization rates should be estimated at 15-20%. In addition, many densitometry costs such as necessary service contracts/software upgrades and office upgrades to allow electronic image transmission were omitted. Finally, CMS concluded that the actual physician work of DXA interpretation is "less intense and more mechanical" than was accepted previously. This conclusion fails to recognize that high quality DXA reporting requires skilled interpretation of the multiple results generated by the instrument.

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

Thank you,

Susan Chambers, MD

Submitter : Dr. Valerie Engelbrecht **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1695-Attach-1.DOC

Attach
1695

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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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Thank you,

Valerie Engelbrecht, MD

Submitter : Dr. Sharla Helton **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1696-Attach-1.DOC

Attach #
1696

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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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equipment utilization rates should be estimated at 15-20%. In addition, many densitometry costs such as necessary service contracts/software upgrades and office upgrades to allow electronic image transmission were omitted. Finally, CMS concluded that the actual physician work of DXA interpretation is "less intense and more mechanical" than was accepted previously. This conclusion fails to recognize that high quality DXA reporting requires skilled interpretation of the multiple results generated by the instrument.

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

Thank you.

Sharla Helton, MD

Submitter : Mrs. Stephanie Reimer **Date:** 08/17/2006

Organization : Mrs. Stephanie Reimer

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1697-Attach-1.TXT

H 17[illegible]
1697

August 17, 2006

Dear Centers for Medicare and Medicaid Services,

I am a health care professional currently working in Women's Health and I am writing to express my concerns and objections regarding your proposed Medicare reimbursement for DXA scans. DXA and VFA testing is very important in the evaluation and management of patients with suspected osteoporosis.

The proposed cut in reimbursement for DXA testing are at odds with multiple Federal initiatives to reduce the personal and societal cost of osteoporosis. The Bone Mass Measurement Act, the US Preventative Task Force recommendations and the Surgeon General's Report on Osteoporosis all underscore the importance of DXA in the prevention and treatment of osteoporosis. These 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.

Also, some of the assumptions used to recalculate the Medicare Physician Fee Schedule were inaccurate. CMS calculated the practice expense, utilizing pencil beam instrumentation at a cost of $41,000, instead of the $85,000 assigned to VFA, which is done on fan beam densitometers. Our office instrument is fan beam, as is the vast majority of densitometers currently in practice, so the equipment cost for DXA should be listed at $85,000.

In addition, the proposed reimbursement of approximately $40.00 does not even cover the cost of operation for our DXA system, and therefore will have a significant impact on patient access to osteoporosis screening with consequent decline in quality osteoporosis care. The equipment rate utilization that CMS has assigned to DXA assumes that all diagnostic equipment is in use 50% of the time, based on high volume imaging centers. However, diagnostic equipment (such as DXA and VFA) which is used to evaluate single disease states, should be expected to have lower utilization rates estimated at 15-20%.

I work very hard to provide the highest quality of patient care and prevention of disease, and this proposed reduction in reimbursement will deeply impact my ability to offer my patients the osteoporosis screening they need. The cost of the machine, the cost of the maintenance contract, the cost of qualified DXA technicians, and the cost of skilled interpretation, will result in my inability to provide this beneficial service. Without available DXA testing, the patients that I serve will pay the ultimate price: they are the ones who will go undiagnosed and untreated for osteoporosis, a very treatable disease. They are the ones who will suffer with unnecessary fractures, loss of productivity and disability. The costs to CMS ultimately will be greater as fractures, hospitalizations, medications, and disability issues arising from lack of testing and treatment for osteoporosis arise.

I sincerely urge you to reconsider your proposal to reduce reimbursement for DXA and VFA testing in the evaluation and management of patients with suspected osteoporosis.

Sincerely,

Stephanie Reimer, RN, BC, BSN, CDE

Submitter : Dr. Deborah Huff **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1698-Attach-1.DOC

HHaccett
1698

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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

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

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

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

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

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

Importantly, it appears that some of the assumptions used to recalculate the Medicare Physician Fee Schedule were inaccurate. For example, CMS calculated the equipment cost at less than half of what it should be, because they based it on older pencil beam technology that is now infrequently used. They also calculated the utilization rate for this equipment at a falsely high rate that does not reflect the average use of equipment used to evaluate single disease states. Rather than the 50% rate assigned, DXA and VFA

equipment utilization rates should be estimated at 15-20%. In addition, many densitometry costs such as necessary service contracts/software upgrades and office upgrades to allow electronic image transmission were omitted. Finally, CMS concluded that the actual physician work of DXA interpretation is "less intense and more mechanical" than was accepted previously. This conclusion fails to recognize that high quality DXA reporting requires skilled interpretation of the multiple results generated by the instrument.

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

Thank you,

Deborah Huff, MD

Attach # 1699

SPORT AND SPINE PHYSICAL THERAPY INC

"better for life"

sportandspine.net

Dry Creek: 720-493-1181 • fax 720-493-1191
7340 S. Alton Way, 11-D • Centennial, CO 80112

Inverness Athletic Club: 720-873-6866 • fax 720-873-6875
374 Inverness Parkway • Englewood, CO 80112

Ken Caryl: 303-996-8024 • fax 303-996-8025
12664 W. Indore Place • Littleton, CO 80127

Brighton: 303-655-8699 • fax 303-655-8698
2418 E. Bridge Street • Brighton, CO 80601

August 17, 2006

To Whom It May Concern:

My name is Joanna Goldin and I'm a physical therapist who owns a small private practice in Colorado. I have been a licensed physical therapist since 1983 and have been practicing in Colorado since 1992. I opened my own therapy practice in 1998 and now employ 22 people in the Denver metro area. I wish to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for the calculating practice expense RVUs under the Medicare physician fee schedule.

I am urging the Centers for Medicare and Medicaid Services (CMS) to make sure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. I know that the federal government is always looking for ways to cut the budgets, but realistically, if they focused on the fraud and mismanagement of funds, there would be a dramatic decrease in the amount of spending on healthcare industries. According to the Office of Inspector General, Dept. of Health and Human Services, May, 2006 report, approximately 91% of physical therapy billed to Medicare by Physicians in the first 6 months of 2002 did not meet Medicare requirements. These inappropriately paid services cost the Medicare program and its beneficiaries approximately $136 million! These are the items that should be addressed by CMS to help save the Medicare system for the people who need it and should be given the best services available.

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

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

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

Thank you so much for your consideration of my comments.

Sincerely,

Joanna Goldin, PT
President, Sport and Spine Physical Therapy, Inc.
7340 S Alton Way, 11-D
Centennial, CO 80112
720.493.1181
www.sportandspine.net

Submitter : Dr. Laura Mackie **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1700-Attach-1.DOC

Attach F
1700

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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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Thank you.

Laura Mackie, MD

Submitter : Dr. Virginia Vaughan **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1701-Attach-1.DOC

H Hall #1701

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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

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

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

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

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

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

Importantly, it appears that some of the assumptions used to recalculate the Medicare Physician Fee Schedule were inaccurate. For example, CMS calculated the equipment cost at less than half of what it should be, because they based it on older pencil beam technology that is now infrequently used. They also calculated the utilization rate for this equipment at a falsely high rate that does not reflect the average use of equipment used to evaluate single disease states. Rather than the 50% rate assigned, DXA and VFA

equipment utilization rates should be estimated at 15-20%. In addition, many densitometry costs such as necessary service contracts/software upgrades and office upgrades to allow electronic image transmission were omitted. Finally, CMS concluded that the actual physician work of DXA interpretation is "less intense and more mechanical" than was accepted previously. This conclusion fails to recognize that high quality DXA reporting requires skilled interpretation of the multiple results generated by the instrument.

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

Thank you.

Virginia Vaughan, MD

Submitter : Dr. Teresa Folger **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1702-Attach-1.DOC

Attach #
1702

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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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Thank you.

Teresa Folger, MD

Submitter : **Dr. Jennifer Nelson** **Date: 08/17/2006**

Organization : **Oklahoma City Gynecology & Obstetrics**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1703-Attach-1.DOC

HHeh # 1703

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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.

Jennifer Nelson, MD

Submitter : **Dr. Dana Stone** **Date: 08/17/2006**

Organization : **Oklahoma City Gynecology & Obstetrics**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1704-Attach-1.DOC

1744
1704

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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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Thank you.

Dana Stone, MD

Submitter : **Dr. Andrea Doeden** **Date: 08/17/2006**

Organization : **Oklahoma City Gynecology & Obstetrics**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1705-Attach-1.DOC

H-Hoff
1705

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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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Thank you,

Andrea Doeden, MD

Submitter : **Dr. Margaret Hall** **Date: 08/17/2006**

Organization : **Oklahoma City Gynecology & Obstetrics**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1706-Attach-1.DOC

HHaC/1FF
1706

Dear Dr. McClellan:

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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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Thank you,

Margaret Hall, MD

Submitter : Dr. Donna Seres **Date:** 08/17/2006

Organization : Oklahoma City Gynecology & Obstetrics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1707-Attach-1.DOC

Attach #
1707

Dear Dr. McClellan:

I am an OB/GYN who provides care for women. I see the devastative effects of osteoporosis to the patient and healthcare system. I also see the improvement in bone mass and reduction of life changing hip fractures which is possible through consistent screening and treatment.

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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Thank you.

Donna Seres, MD

Submitter : **Dr. Steven Taylor** **Date: 08/17/2006**

Organization : **GI Consultants**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

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

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

Dear Doctor McClellan:

I am a practicing gastroenterologist in Carson City, Nevada and have been a Medicare participating provider since 1993. Thank you for the opportunity to comment regarding the proposed changes to the Physician Fee Schedule for 2007.

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

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

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

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

Thank you for your consideration of my comments.

Sincerely,

Steven D. Taylor MD

Submitter : **Dr. Marsha Melnick** **Date: 08/17/2006**

Organization : **Neuroclin2**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

To Whom It May Concern:

I am a Physical Therapist who has practiced in the area of pediatrics and neurological physical therapy for 38 years. In addition to my clinical experience, I have also taught neuroscience and clinical application for physical therapists for 27 years. During some of my teaching experience I was also involved in teaching medical students and residents. I therefore feel qualified to comment on the changes proposed in the work relative value units and the methodology for counting the RVU under the Medicare physician fee schedule (per June 29 announcement).

As proposed 2007 will be a devastating year for physical therapists. The proposed changes will severely impact physical therapists as physical therapists (as well as other non-physicians) cannot bill under the E/M code and so will not benefit from the increase in that category. If these cuts are necessary, they need to be transitioned over 4 years to ensure that patient care is not jeopardized. If payments are cut so severely, access to care, especially in the rural area in which I now practice, will be at risk. In my present practice I see patients who would have no access to another provider with my specialized skills unless they could travel 2 hours to the nearest major city. My patients benefit from my individualized treatment many of my patients who had had a stroke were confined to a wheelchair on their first visit and now all are walking and rejoining the community. Yet these services will be reduced in value. This reduction in value does not seem to be commensurate with the services provided nor in the best interest of patient care.

I would be happy to provide you with any further information and thank you for reading this letter.

Sincerely,

Marsha E. Melnick, PT, PhD
Professor Emerita, Graduate Program in Physical Therapy
University of California San Francisco/ San Francisco State University

Consultant
Neuroclin2

Submitter : Dr. Stephen Kennedy **Date:** 08/17/2006

Organization : Elk Grove Bone Densitometry Ctr

Category : Physician

Issue Areas/Comments

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

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

My practice in California consists entirely of providing DXA studies for the diagnosis of osteoporosis. I am very concerned about the proposed drastic cuts in payment for dual energy X-ray absorptiometry (DXA; CPT code 76075) & vertebral fracture assessment (VFA; CPT code 76077), proposed as part of a new five-year review of the Medicare Physician Fee Schedule. If not reversed, when fully realized, these cuts would amount to 71% for DXA & 37% for VFA. This will severely reduce the availability of high quality bone mass measurement, having a profound adverse impact on patient access to good skeletal healthcare. Ironically, these cuts are completely contrary to recent forward-looking Federal directives, 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, that all highlight the importance of osteoporosis recognition using DXA, & the value of appropriate prevention & treatment to reduce the personal & societal cost of this disease (also underscored by HEDIS guidelines & the recent NCQA recommendations). These patient-directed Federal initiatives, coupled with the new medications for the prevention & treatment of osteoporosis, have improved skeletal health & dramatically reduced osteoporotic fractures, saving Medicare dollars in the long run. Also, unlike other imaging procedures where costs are escalating but improvements in patient outcome have not been clearly demonstrated, DXA & VFA are of relatively low cost & of proven benefit. DXA & VFA are readily available now to patients being seen by primary care physicians & specialists alike, thus assuring patient access to these essential studies. Importantly, some assumptions used to recalculate the Medicare Physician Fee Schedule appear inaccurate, i.e., 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 rarely used. They also calculated the utilization rate for this equipment at a falsely high rate of 50% that does not reflect the average use of equipment used to evaluate single disease states of 15-20% for DXA & VFA. Also, many costs such as necessary service contracts/software upgrades & office upgrades to allow electronic image transmission were omitted. Finally, CMS concluded that the actual physician work of DXA interpretation is "less intense & more mechanical" than was accepted previously--this fails to recognize that high quality DXA reporting requires skilled interpretation of the multiple results generated. I have had many patients for whom the most important outcome is what did NOT happen. As a result of DXA & VFA studies I performed, a large number of patients were diagnosed with osteoporosis, received treatment, & as a result did not have catastrophic fractures. A typical example is a 66 year old woman who had never had a BMD test & on the screening DXA study with VFA performed at my office was found to have both osteoporotic T-scores & vertebral compression fractures. She was at very high risk of more fractures, including a possible disabling or even fatal hip fracture. She was treated with an oral bisphosphonate & upon follow-up DXA with VFA 15 months later was found to have had a statistically significant increase in hip & lumbar spine BMD & no new 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 & treated, thereby preventing unnecessary pain & disability, preserving quality of life & minimizing the significant societal costs associated with bone fractures. Please do all you can to support bone health & quality patient care by requesting that these proposed cuts be reversed.

Submitter : Mr. Glenn Hackbarth **Date:** 08/17/2006

Organization : MedPAC

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1711-Attach-1.PDF

Attach
#1111

MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

August 17, 2006

Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Box 8013
Baltimore, Maryland 21244-8013

RE: file code CMS-1512-PN

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled: *Medicare program; Five-year review of work relative value units under the physician fee schedule and proposed changes to the practice expense methodology.* [CMS-1512-PN] Federal Register, June 29, 2006. We appreciate your staff's ongoing efforts to administer and improve the payment system for physicians' services, particularly considering the agency's competing demands.

The 5-year review process

CMS recently completed its third five-year review of the physician fee schedule's work relative value units (RVUs) and has proposed changes to the work RVUs of 253 codes. As in past reviews, CMS relied heavily on specialty societies to identify codes that might be misvalued and to collect supporting data, and on the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) to evaluate the data and make recommendations. In previous five-year reviews, the RUC recommended far more increases than decreases in the relative values of codes. This was in large part because the specialty societies, which identified the vast majority of the misvalued services examined by the RUC, have financial incentives to pursue correction of undervalued services.

For the third five-year review, CMS continued to rely on specialty societies to identify misvalued codes, but also itself identified 168 codes for RUC analysis. Still, only a small number of these codes were identified as codes thought to be overvalued.

The Commission continues to be concerned by the overwhelming number of undervalued codes identified and corrected during the five-year-review process, as compared to the number of overvalued codes. CMS proposes to increase the work RVUs for 225 codes and decrease the

RVUs for only 28 codes. This suggests that overvalued services continue to be largely ignored by the current process. Such misvaluation can distort the market for physician services (as well as for other health care services that physicians order, such as hospital services). Services that are overvalued may be overprovided because they are more profitable than other services. In addition, because so many more codes would have their values increased than decreased, CMS would passively devalue all work RVUs by an estimated 10 percent, in keeping with the budget neutrality requirement.

In its proposed rule, CMS acknowledges that there is little incentive for physician specialty societies to identify codes that may be overvalued for review. Nevertheless, CMS has not yet proposed any alternative method for identifying such services in the next five-year review, and maintains that it is the responsibility of the specialties to present compelling evidence that a code is misvalued. However, CMS appears to have taken a more critical approach to its review of the RUC's recommendations, accepting only 71 percent, compared with more than 90 percent in previous years.

In our March 2006 Report to the Congress, MedPAC evaluated the five-year-review process and concluded that CMS itself must take a more central role in identifying potentially misvalued services, especially overvalued ones. We recommended that CMS reduce its reliance on physician specialty societies by establishing a standing panel that would provide expertise in addition to that provided by the RUC. This new panel would help CMS identify misvalued services and collect data to establish supporting evidence for the RUC to consider. The panel would also be useful in evaluating codes when no specialties express an interest in collecting the necessary data, as happened with the case of one code.

The Commission also recommended that the Secretary implement reviews of services based on analyses of Medicare data, institute automatic reviews of work RVUs for selected recently introduced services after a specified period, and establish a process by which all services are reviewed periodically. We recognized that these recommendations would increase demands on CMS and—since the goal was to improve the accuracy of Medicare's payments and achieve better value for Medicare spending—encouraged the Congress to provide the agency with the financial resources and administrative flexibility to undertake them.

Our recommendations were not intended to supplant the RUC but rather to augment it. The RUC and the specialty societies play an important role, which should continue. The RUC is currently in the process of reviewing its own procedures, including its composition, its role in the identification of misvalued services, and its processes for identifying and reviewing newly introduced services. It remains to be seen whether and how changes to the RUC's procedures will affect the review of services in the next 5-year review.

Other issues under the five-year review

As proposed, the work RVUs for many evaluation and management services would increase. We commend the RUC for recommending these increases and CMS for agreeing with the RUC. The Commission has expressed particular concern about primary care services, which have been found to be capturing a smaller portion of Medicare physician spending. If it continues, such a

shift in spending would have important implications for the future of the physician workforce necessary to meet the chronic care and other needs of Medicare beneficiaries.

The proposed rule also discusses the global surgical policy. Although it is not proposing any changes to the policy at this time, CMS voiced its interest in receiving comments concerning the current policy of including post-operative visits in the global surgical packages and what advantages or disadvantages might be associated with unpackaging these visits.

Compared to other payment systems, the unit of payment in the physician fee schedule is very narrow in that it consists of many discrete services—visits, imaging studies, laboratory and other diagnostic tests, and procedures. MedPAC has long been concerned that such a unit of payment might give physicians a financial incentive to increase payments by increasing the volume of services unnecessarily. Indeed, at the time the global surgical packaging policy was implemented, policy makers believed that some physicians were billing for unnecessary post-operative visits. In the absence of information suggesting that access to appropriate care is being compromised, the Commission continues to support packaging and bundling to encourage efficient and appropriate care.

Practice expense

CMS is proposing the first major overhaul of the method it uses to calculate practice expense payments since it implemented resource-based practice expense RVUs in 1999. Under the proposal, CMS will:

- Calculate direct practice expense RVUs using a "bottom-up" method instead of a "top-down" method,
- Modify the method it uses to allocate indirect costs to specific services,
- Use supplemental practice cost data from eight specialties to calculate indirect practice expense RVUs, and
- Eliminate the non-physician work pool and calculate the practice expense RVUs for all services using the same method.

Calculating direct practice expense RVUs

CMS proposes to calculate direct practice expense RVUs by summing the costs of the direct inputs for each service. In the Clinical Practice Expert Panel (CPEP) database, the agency maintains the types, quantities, and prices of the direct inputs—clinical labor, medical equipment, and supplies—required to provide each service paid under the physician fee schedule.

The proposed "bottom-up" method is more understandable and intuitive than the current "top-down" method in which CMS allocates total practice expenses to specific services using the direct inputs. Under the bottom-up method, it is not necessary to estimate the total direct costs of operating a practice and allocate these costs to specific services. However, moving to a bottom-up method will redistribute direct practice expense RVUs across services because the method relies solely on the cost of the direct inputs. Services that require costly equipment and supplies, such as some non-facility imaging services and procedures, will probably experience more gains on average than other services, such as evaluation and management services.

Therefore, it is important that CMS ensure that the inputs—types, quantities, and prices—are accurate and complete. Otherwise, the relative weights for practice expense will become distorted. Under CMS's proposal, the direct inputs play a greater role in determining both the direct and indirect practice expense RVUs than under the current method. CMS should address at least three issues to ensure the accuracy of the direct input estimates and their prices.

First, CMS, with the assistance of the medical community, should obtain estimates for services that are not currently valued as soon as feasible. Otherwise, Medicare's payment for these services may not reflect the resources that practitioners require to furnish them. For example, direct input estimates are lacking for the monthly capitated services that physicians provide to dialysis patients (codes G0308–G0327). Under the proposed bottom-up method, practice expense RVUs (fully implemented) for these services will decline by 22 percent to 64 percent compared with current (2006) values. In last year's proposed rule, CMS noted that they did not have estimates of the direct inputs for these services.

Second, CMS should revisit how it estimates the per service price of medical equipment, in particular the assumptions that all equipment is operated half the time that practices are open for business and that practices pay an interest rate of 11 percent when borrowing money to buy equipment. It is critical that CMS update these assumptions because it proposes to use estimates of clinical labor, equipment, and supplies to value services that are currently in the non-physician work pool (see discussion below). Until now, the practice expense RVUs for such services have been primarily based on historical charges. Many imaging and radiation therapy services that are currently in the non-physician work pool use high-cost equipment. If CMS overestimates the cost of such equipment, the RVUs for these codes under the proposed bottom-up method will be too high.

If providers use equipment more than 50 percent of the time, Medicare's prices for equipment are too high. We conducted a survey of imaging providers in six markets that indicates that providers in those markets use magnetic resonance imaging (MRI) machines more than 90 percent of the time and computed tomography (CT) machines more than 70 percent of the time (MedPAC, Report to the Congress: Increasing the value of Medicare, 2006). Our survey raises questions about whether CMS underestimates how frequently providers use MRI and CT equipment.

CMS could update its utilization assumptions for high-cost equipment by including questions about equipment use in a new multi-specialty survey of practice costs. (Inexpensive equipment is a lower priority because it represents a small fraction of a service's practice expense.) Alternatively, CMS could base the assumption of equipment use on an expectation of how frequently efficient providers operate expensive equipment. Such a standard would encourage more efficient use of high-cost equipment.

CMS also assumes that practitioners pay an interest rate of 11 percent per year when borrowing money to buy equipment, but more recent data from the Federal Reserve Board suggest a lower

interest rate may be more appropriate. A lower interest rate estimate would reduce payment rates for services that have high equipment costs. CMS has not updated the current estimate since it was developed in 1997.

The Federal Reserve Board conducts an ongoing survey that CMS could use to revise its interest rate assumption. The Board collects quarterly information on commercial and industrial loans made by commercial banks to different types of borrowers. One of the advantages of using this survey is that it is updated regularly, which would make it easier for CMS to keep its assumption up to date. Based on the Federal Reserve surveys conducted during the last five years (from the second quarter of 2001 to the first quarter of 2006), loans of more than one year had average annual interest rates over the last five years that ranged from 5.3 percent to 6.0 percent, depending on the risk of the loan.

Third, the agency should establish a reasonable time frame to periodically review and update the wage rates for clinical staff and the purchase prices of supplies and equipment. CMS should also review the prices of expensive supply and equipment items more frequently than other items. Staff wages and the prices of equipment and supplies have a greater impact on RVUs under a bottom-up method than a top-down method.

CMS last updated nonphysician clinical staff wages for the 2002 fee schedule and has not indicated when wages will be reviewed again. Because wages for different types of clinical staff increase at different rates, PE RVUs could become less accurate over time unless wage data are kept up to date.

Although CMS repriced supplies and equipment in the last few years, the agency has not indicated when it will next perform a comprehensive review. Moreover, the prices of new, high-cost supplies and equipment should be reviewed more frequently than other items to ensure that price changes are reflected in the relative values. Prices for new items are likely to drop over time as they diffuse into the market and as other companies begin to produce them.

Calculating indirect practice expense RVUs

Indirect practice expenses, which include office rent, utilities, and administrative staff, cannot be directly associated with specific services. Indirect costs are important because they represent more than half of most specialties' total practice costs. CMS currently uses a top-down approach to allocate aggregate indirect costs to individual codes based on each code's direct practice cost and work RVU. The agency proposes to continue using the top-down method for calculating indirect costs but changes how costs are allocated to specific services. We are concerned that these changes make the methodology less intuitive and understandable. In addition, CMS could describe its proposed method more clearly.

The current method allocates indirect costs to individual services based on the sum of the direct practice cost and physician work RVU for each service. The proposed method makes two changes:

- It adjusts the direct practice cost based on the ratio of indirect to direct practice costs for specialties that perform the service.
- Instead of using the physician work RVU, CMS proposes to use the higher of each service's physician work RVU or clinical labor RVU (e.g., the cost of a nurse's time).

The second change is designed to protect services with little or no work RVUs that might be disadvantaged by the current allocation approach. For example, codes that are currently in the non-physician work pool have no work RVUs. The problem with using clinical labor in addition to direct costs to allocate indirect costs for certain services is that clinical labor is a component of direct costs, which leads to double counting of clinical labor in the allocator. Although this approach seems reasonable for services that have no work RVUs, it is unclear why it should also be applied to services with small work RVUs.

Under the current method, CMS multiplies the indirect cost allocation for each service by a specialty-specific scaling factor. The scaling factor equals the specialty's aggregate indirect costs based on survey data divided by the specialty's total indirect cost allocation. It ensures that the indirect cost allocation for all services performed by a specialty (based on the direct costs and work RVUs for those services) equals the total indirect costs for the specialty based on survey data. Under the proposed method, CMS creates an indirect practice cost index that reflects the relationship between each specialty's indirect scaling factor and the overall scaling factor across all specialties. For example, if a specialty has a scaling factor of 1.0, and the overall average is 0.5, the practice cost index for that specialty is 2.0 (1.0 divided by 0.5). The practice cost index for each specialty is multiplied by the indirect cost allocation for the services it performs. The rule is unclear on whether the practice cost index differs from the current method.

It is difficult to evaluate the proposed changes to allocating indirect costs because there is no accepted standard for allocating such costs to specific services. Nevertheless, neither the current method nor the proposed method is very intuitive or understandable. We suggest that CMS explore alternatives for allocating indirect costs that would be more understandable. Such research could include:

- whether indirect costs should be allocated based on clinical labor and equipment, but not supplies (the current approach rewards services that use high-cost supplies although it is questionable whether they are associated with higher indirect costs); and
- the impact of allocating indirect costs based solely on the indirect expense ratio for each specialty.

The Commission also plans to examine alternative methods for indirect cost allocation.

CMS should strive to be as transparent as possible given the complexity of the method to calculate indirect practice expense RVUs. CMS could improve the transparency of its proposal by publishing the scaling factors and the indirect practice cost index values for each specialty. In addition, it would be helpful to show the impacts of changes to the indirect method by specialty and categories of services (rather than summarizing the impact of multiple changes to the practice expense methodology in a single table, as in the proposed rule).

Using supplemental data to calculate indirect practice expense RVUs.
CMS is proposing to use more current practice cost data submitted by eight specialties (allergy/immunology, cardiology, dermatology, gastroenterology, urology, radiology, radiation oncology, and independent diagnostic testing facilities) to calculate indirect practice expense RVUs. The Balanced Budget Refinement Act of 1999 (BBRA) mandated that CMS establish a process to consider supplemental data submissions when updating the physician fee schedule. For most other specialties, CMS uses practice cost data that the AMA collected between 1995 and 1999.

As the Commission noted in its June 2006 report, using more current practice cost data submitted by some (but not all) specialties raises several issues. Supplemental submissions do not provide a recurring source of information for all specialties. Although the BBRA gave providers the option to submit more current information, they are not mandated to do so. Since the BBRA, few groups have submitted newer data. Groups informed the Commission that collecting practice expense information is costly and time consuming, and they do so only when it is likely to increase their payment rates. Through 2006, the agency has accepted and used supplemental data from five specialties.

Using more current information from some but not all specialties could cause significant distortions in relative practice expense payments across services. If CMS uses the supplemental submissions from the eight specialties, a redistribution of practice expense RVUs will occur because it will implement the change in a budget neutral manner. Hourly practice expenses increased substantially for the eight groups with supplemental data, ranging from about 40 percent for urology to 125 percent for cardiology and 750 percent for independent diagnostic testing facilities. As a result, once CMS applies specialties' supplemental data in a budget-neutral manner, practice expense payments for services primarily furnished by them will increase while payments for services furnished by other groups will decrease. For example, the practice expense RVUs for destruction of a benign or premalignant lesion (CPT 17000) will increase by 42 percent (from 0.97 RVU to 1.38 RVU). Physicians specializing in dermatology primarily furnish this service, and this group is one of the eight specialties with supplemental data.

The most equitable goal is for the agency to collect comprehensive practice cost data for all practitioner groups on a regular basis. Using current total practice cost data from all specialties is important to ensure the accuracy of practice expense payments.

Eliminating the nonphysician work pool
CMS proposes to eliminate the non-physician work pool (NPWP) and calculate the practice expense RVUs for all services using the same method. CMS created this pool as an interim measure to allocate practice expense RVUs for services that are not performed by physicians, such as the technical component of most radiology services. Practice expense RVUs for NPWP services are primarily based on historical charges, rather than relative resource use. We have been concerned that this method may lead to overvalued RVUs for imaging services (Report to the Congress, March 2005). CMS's proposal to determine practice expense RVUs for codes in

the NPWP using the same resource-based methodology it uses for other services is more intuitive and promising than the current approach and fulfills the statutory mandate that RVUs be resource based.

Ensuring the accuracy of practice expense RVUs
CMS has not yet proposed a five-year review of practice expense RVUs. The agency fully implemented the resource-based values in 2002, which suggests that CMS should review them by 2007. However, the refinements of the direct input estimates continued through the end of 2005.

It is important for CMS to set a reasonable schedule for reviewing practice expense relative weights at least every five years as required and more often for services experiencing rapid changes. The statute requires the Secretary review and make adjustments to the relative values for all physician fee schedule services at least every five years. Periodic review of the RVUs is important because the resources needed to perform a service can change over time. CMS should adjust the value of the service accordingly. Otherwise, Medicare's practice expense payments will be too high or too low, relative to the resources needed to produce it. During the five-year review, CMS could also update the utilization data it uses to calculate indirect practice expense RVUs if it chooses to update the data periodically rather than annually.

A five-year review would give CMS the opportunity to review the estimates of the direct inputs in the CPEP database. The inputs required to furnish many—although not all—services can be expected to change over time. Currently, the RUC recommends the types and quantities of direct inputs for refined and new services to CMS. The agency has generally accepted the RUC's recommendations for most services.

CMS could focus its effort on high-volume services, particularly those for which the RUC based its direct input estimates on values estimated by consensus, not from surveys of physicians. Between 1999 and 2005, the RUC made recommendations to CMS to refine most of the direct inputs from resource estimates proposed by specialty societies. By contrast, for new services, the RUC used data gathered from physician surveys.

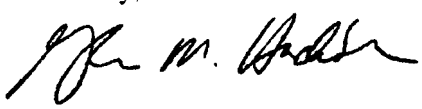
Updating practice expense data and CMS's workload
We recognize that the updating the practice expense data will substantially increase CMS's workload. There is a trade-off between improving the accuracy of practice expense payments and other demands on the agency's limited administrative resources. Therefore, we suggest that CMS focus its efforts on areas where the data are most out of date and the impact on RVUs is likely to be greatest. Although some time lag between relative weights and actual costs is unavoidable, CMS can still develop a reasonable time frame and approach to periodically update the data sources. The Congress should provide CMS with the financial resources and administrative flexibility to undertake the effort as it will improve the accuracy of Medicare's payments and achieve better value for Medicare spending.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/nr/w

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

I am writing as a PT with a multiclinic & multistate physical therapy group. I am writing to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for calculating practice
expense RVUs under the Medicare physician fee schedule. I am urging you the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule. I Recommend that CMS transition the changes to the work relative value units (RVUs) over a four year period to ensure that patients continue to have access to valuable health care services. These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment for these services is cut so severely,access to care for millions of the elderly and disabled will be jeopardized.
Thank you for your consideration!

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

Organization : Erie Physicians Network

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

As an Internist that practices preventative medicine very heavily, I feel it is imperative to screen patients for osteoporosis and treat when indicated. This screening is provided by using a Dexa scanner. Treatment of osteoporosis helps to prevent fractures, especially of the spine and hips. The cost of purchasing and running the scanner is very significant and our projections show that with the propsed cuts our dexa scanner would become a losing venture and we would need to close this important service to our patients. I would tend to believe that most centers would need to close and that eventually the advance we have made in treating this silent disease would be lost.

Submitter : Mrs. Marti Peplinski-Duquette **Date:** 08/17/2006

Organization : CPTI

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

My name is Marti Peplinski-Duquette. I am a staff physical therapist working at Colorado Physical Therapy Institute. This is a therapist-owned, out-patient clinic that has been in operation since 1987. I have practiced as a physical therapist for the past 7 years.

I recently became aware of the June 29th proposed notice by CMS to reduce the relative work values for services provided by physical therapists and other professionals who bill Medicare under the physician fee schedule. This will cause a payment reduction to physical therapists by 6% in 2007. I urge you to please ensure that these severe Medicare payment cuts do not occur. These cuts will only cause more patient access limitations to the care they need and deserve.

Although increasing payment for E/M services is important, physical therapists cannot bill for E/M codes and will not benefit from these proposed increases. The value of services by all Medicare providers should be acknowledged under this payment policy. If not, 2007 will be a devastating year for physical therapists and all non-physicians who are not allowed to bill E/M services.

This brings to the forefront another extremely important issue involving physician-owned physical therapy services (POPS). These services have negatively impacted the Medicare program. These referral for profit services translate into higher healthcare costs for both consumers and payors because they generate more utilization and higher charges than do autonomous practitioners. A recent report by the Office of the Inspector General of the Department of Health and Human Services, in May of 2006, concluded that approximately 91 percent of physical therapy billed to Medicare by physicians in the first 6 months of 2002 did not meet Medicare requirements. These inappropriately paid services cost the Medicare program and its beneficiaries approximately $136 million.

In addition, a study in the Journal of the American Medical Association revealed that visits per patient were 39% to 45% higher in physician-owned clinics when compared with therapist-owned clinics; revenue per patient was 30% to 40% higher in facilities owned by referring physicians. Substantial evidence supports the belief that the independent practitioner delivers better quality of care, more cost-effectively, than therapy provided in clinics owned by physicians.

I strongly believe that the above mentioned reports provide ample reason for the CMS to acknowledge, value, and properly reimburse the services that physical therapists provide.

I want to thank the Administrator for his consideration of my comments.

Sincerely,
Marti Peplinski-Duquette MSPT

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

Organization : **Pat Laurenz**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am concerned about the proposal to reduce Medicare reimbursement to mental health providers. Such a cut in reimbursement would most certainly adversely affect my practice and ability to continue to serve as a Medicare provider. Reimbursement rates from Medicare, Medicaid and Managed Care Companies have remained at the same level for a good number of years. Conversely, our operating costs and overhead continue to rise each year with increasing energy and maintenance costs. It would appear that this move would adversely affect a great number of mental health care providers and decrease the number of competent available clinicians to treat Medicare patients. Thank you for your time and consideration.

Submitter : Ms. Phyllis Rosen **Date:** 08/17/2006

Organization : Ms. Phyllis Rosen

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

I am outraged and angered at the idea that clinical social workers would receive a decrease in reimbursement over the next 10 years. Clinical social workers are direct providers and barely exist above the poverty level themselves. It would be impossible to exist on the cuts proposed. Medicare needs to consider the fact that the population is aging and that social workers are the main providers of service. Please do not consider increasing the reimbursement for Evaluation and Management codes until the issue of reimbursement is settled in an equitable manner. Please do not approve the "bottom Up " formula to calculate practice expenses. We need to pay social workers in a professional and appropriate manner commensurate to their experience and expertise. Thank you. Phyllis Rosen

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

Organization : Towncrest Internal Medicine

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I practice general Internal Medicine in Iowa City, Iowa, in a private practice setting with thirteen partners. We all do general Internal Medicine.

I encourage you to adopt the proposed E/M changes to increase the RVU s.
The patients that I care for are becoming increasingly complex. As an example, Mrs. M. R. is a 75-year-old, white female, who I first stated taking care of 16 years ago when I returned to Iowa City. She has accumulated medical problems over the last 16 years, the last 10 as a Medicare patient, which include the following:
1. Hypertension
2. Diabetes mellitus Type 2 with retinopathy, diabetic nephropathy, and peripheral neuropathy
3. Hyperlipidemia
4. Obesity
5. Coronary artery disease: status post coronary artery bypass and angioplasties
6. Chronic renal insufficiency (BUN and creatinine 80 and 3.1, respectively)
7. Anemia of chronic disease: hemoglobin 9.4
8. Thrombocytopenia
9. Vulvar carcinoma surgery at the local University medical center
10. Congestive heart failure
11. Cerebrovascular disease status post TIA s
12. Gout
13. Status post GI bleeding
14. Right subclavian stenosis

She is on 14 prescription medicines. I need to see her on a regular basis. Just to go through the list of her medications and make sure there have been no problems takes a lengthy period of time. She is good patient in the sense that she comes on a regular basis. She comes to her appointments. She follows direction and we are able to make decisions together in terms of what is best for her. The multitude of her problems is such, however, that every single time she comes in it is a lengthy visit, it requires careful consideration of her multiple problems. She is walking a tightrope and any little problem cascades into further problems.

Her husband: Mr. R.R., is a 77-year-old, white gentleman, with:
1. Hypertension
2. Gout
3. Cerebrovascular disease with TIA s
4. Coronary artery disease status post CABG and angioplasties
5. Hyperlipidemia
6. Diabetes mellitus Type 2
7. Chronic renal insufficiency
8. Recurrent prostatitis
9. Spinal stenosis with sciatica

He is the healthier of the two, but when he comes in for his appointments, his problems are also complex in terms of just trying to sort out the multiple complaints and medications. He also is walking a medical tightrope. I have followed him for 16 years and over these years the problems have become increasingly complex.

Mr. F.H. is a healthy, 77-year-old gentleman, who first came to me 5 years ago. His previous physician had retired at that time and he ended up driving 60 miles here because he could not find a closer physician who would take new Medicare patients with his problems, which included colon cancer and kidney stones. During the time I have taken care of him, I have diagnosed prostate cancer (treated with a radical prostatectomy) and more recently, diabetes. He is doing well despite all of this but again, it was not I who refused to see him, as he drove some 60 miles across the state from one doctor to another, but rather I was the doctor who accepted him for care here in Iowa City. Historically, I have taken any new patient who walks through the door, whether it be Medicare, Medicaid, insurance or no insurance. Clearly, not everyone does this. Mr. F.H. is driving 60 miles to see me because evidently there are not doctors between here and there who will take new Medicare patients.
I enjoy taking care of complicated patients; I find it challenging and rewarding work. Nevertheless, it is not simple. It is not straightforward. This last weekend, while on call for my partners I received calls from patients in their mid-70 s, calling to me about their parents (who are also our patients) who are in their mid-90 s. Trying to make medical decisions on patients in their mid-90 s via telephone is not an easy thing to do, either. We receive no financial compensation for services such as this.

Submitter : **Dr. Brian Dobbins** **Date: 08/17/2006**

Organization : **Prevea clinic**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

attaching comments

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

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

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

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

Organization : medtech mammography centers

Category : Radiologist

Issue Areas/Comments

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

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

The proposed reduction in pay for dxa and mammo cad will be devastating for the profession. This comes at a time when we already have a shortage in this area of medicine. Any reduction in mammo related reimbursement will have huge consequences for american women. These services are under paid presently, with no room to cutt.

Submitter : **Mrs. Cynthia J. Rapp** **Date: 08/17/2006**

Organization : **Portland State University MSW Student**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam:

As a second year M.S.W. student at Portland State University, I am writing to respectfully request that you withdraw the proposed increase in evaluation and management codes until funds to increase reimbursement for all Medicare providers are secured. Further, please do not reduce work values for clinical social workers. Finally, please do not approve the proposed "bottom up" formula to calculate practice expense. Selecting a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers is the preferred option.

Thank you for the opportunity to comment.

Sincerely,

Cindy Rapp
3113 NE Skidmore Street
Portland, OR 97211

Submitter : Ms. Linda James **Date: 08/17/2006**

Organization : Breast Diagnostic Center

Category : Other Health Care Professional

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 pencil-beam technology that was used for your review, this higher technology need to be taken into consideration.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.

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

Organization : CPTI

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

My name is Tammy Wolfe. I've been practicing physical therapy for 23 years, mostly in out-patient facilities. I was made aware of the CMS proposal to reduce relative work values for physical therapy services. This will cause a payment reduction of 6% in 2007. I would like to ask you to reconsider those pay reductions. I believe that cutting payment to physical therapists will limit the treatment time and quality that physical therapists will be able to provide. I know that E/M codes are being increased, but physical therapists are not allowed to charge those codes and will not benefit from the increases. Having to take the decreases in payment without benefiting from the increases will devastate physical therapists who are currently providing excellant care, as well as other providers who may not charge E/M codes.

I would like to comment on the physician owned physical therapy practices also. POPS have been shown in a recent study done by the American Medical Association that physician owned clinics produced revenue that was 30% to 40% higher per patient than non-physician owned practices. The Office of the Inspector General of the Department of Health and Human Services reported that approximately 91% of physical therapy billed to Medicare by physicians in the first 6 months of 2002 did not meet Medicare requirements. I believe that these reports provide reason for the CMS to acknowledge the value of physical therapy treatments performed by physical therapist owned facilities and to acknowledge the need to fairly reimburse for services provided. Thank you for considering my thoughts on these very important topics.

Sincerely,

Tammy Wolfe, PT