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

Organization : **Upper Mississippi Mental Health Center**

Category : **Social Worker**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

Please withdrawn the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Medicare providers. I am a clinical social worker in a rural area. Our mental health center is already financially strapped as a result of low reimbursement rates for our services as the majority of our clients are Medicare and Medicaid recipients. Please do not reduce work values for clinical social workers. We are the primary providers of mental health services to the elderly, chronically mental ill and poor and we can not afford further reimbursement cuts. Thank you for considering my comments. Jean Greseth

Submitter : **Mrs. Greta Leonard** **Date: 08/17/2006**

Organization : **Snake River Osteoporosis Support Group Coordinator**

Category : **Nurse**

Issue Areas/Comments

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

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

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

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

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

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

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

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

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

As the coordinator of the Snake River Osteoporosis Support Group, I see the affects of osteoporosis on a daily level.

I urge you to contact the Centers for Medicare and Medicaid Services Administrator Mark McClellan to ask him 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 U.S. 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,

Greta Leonard RN, CDT
Idaho Osteoporosis Center
4400 E Flamingo Ave
Nampa, ID

Submitter : **Mrs. Angela Stapleton** **Date: 08/17/2006**

Organization : **Stapleton Family Health Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 17, 2006

Regarding File Code: CMS-1512-PN

To Whom It May Concern:

It has come to my attention that Medicare is planning on changing their reimbursement rates for dual energy x-ray absorptiometrys (DXA). This will have significant negative impact on my patient s ability to access osteoporosis screening.

After research, I have seen several errors as to the assumptions regarding operating costs and utilization of DXA systems. Virtually all systems, including our own, use a fan beam, not the assumed pencil-beam technology. This assumption on beam technology is a serious underestimation of the actual costs of providing state of the art osteoporosis screening.

A cut in DXA reimbursements will negatively impact women s access to this important test. Please call 816-903-8880 with any questions or concerns.
Sincerely,
Angela K Stapleton, MD

Submitter : **Dr. Ruth GREER** **Date: 08/17/2006**

Organization : **NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK**

Category : **Social Worker**

Issue Areas/Comments

Other Issues

Other Issues

A 14% reimbursement cut will make it impossible for me to continue being a medicare provider. Please do not lower fees or reduce work values for social workers. Please withdraw proposed increase in evaluation and management fees until there are sufficient funds to increase reimbursement for all medicare providers. Please select a formula to calculate practice expense that does not create a negative impact for clincal social workers.

Submitter : Dr. Timothy Shipe **Date:** 08/17/2006

Organization : Dr. Timothy Shipe

Category : Physician

Issue Areas/Comments

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

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

I am an anesthesiologist currently practicing in Chesapeake VA. As your current policy now stands, anesthesiologists along with other specialties, face a huge payment cut over the next five years. The proposed change in PE methadology hurst anesthesiology more than most specialities. The data that CMS uses to calculate overhead expenses is outdated and significantly underestimates acutal expenses.

If the issue of undervaluation is not addressed by CMS, there will be a shortage of anesthia care to our most vulnrerable populations. Please choose now to make a difference before this problem becomes a crisis.

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

Organization : **Northwest Cardiac and Vascular Imaging, LLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1728-Attach-1.DOC

Northwest and
Cardiac VASCULAR
imaging

122 West 7th Avenue, Suite 545 ▫ Spokane, Washington 99204 ▫ 509.462.0071 ▫ 509.462.0013

Attach# 728

August 17, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (June 29, 2006); Comments re: Practice Expense

Dear Mr. McClellan:

On behalf of Northwest Cardiac and Vascular Imaging, LLC and our 29 individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

Northwest Cardiac and Vascular Imaging, LLC is located at 122 W 7th Avenue, Suite 545, Spokane, WA 99204, and currently owns one diagnostic cardiac catheterization laboratory. Our 29 cardiologists perform approximately 1,000 diagnostic cardiac catheterization procedures per year in this outpatient facility. Provided within this facility are the appropriate and necessary support personnel (RN, tech, etc.) and equipment to ensure high quality state of the art care.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact of the proposed methodology on procedures with significant TC costs because they share the same problems that we will outline below. We also believe that the same solution should be applied to all of the procedures listed below.

With regard to catheterizations, the proposed change in PE RVUs would result in a 53.1 percent reduction of payments for CPT 93510 TC. Similarly, payment for two related codes—93555 TC and 93556 TC would be reduced substantially. In fact, under the Medicare Physician Fee Schedule ("PFS"), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate for these three codes to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	Description
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom up micro-costing approach is laudable and consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comport with the statutory requirement that would match resources to payments. After reviewing the proposed methodology, including the 19 step calculation, we have identified several flaws that result in the PE RVU underestimating the resources needed to provide the technical component of cardiac catheterizations. We will address our concerns with the calculation of direct costs and indirect costs separately, as set forth below.

Direct Costs

The estimate of direct costs is critical for the first step in calculating the PE RVU for each procedure code. The direct costs are based on inputs from the American Medical Association's RVS Update Committee ("RUC") and reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. The RUC-determined direct costs do not reflect estimates of additional labor, supply and equipment costs that were submitted by (The Society for Cardiovascular Angiography and Interventions ("SCAI") or an industry group). As a result, the RUC-determined cost estimate is about half of the estimate that would result if all of the data were included. The addition of these additional costs which are consistent with the RUC protocol would increase the proposed PE RVUs by 24 percent.

Even if the RUC estimates included the additional costs submitted by SCAI or an industry group, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns. For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients. Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

Unless the RUC considers the actual costs of the clinical labor, supply and equipment used to perform a cardiac catheterization, the PE RVU that results at the end of the 19 step calculation will never reflect the actual resources needed to perform the procedure and will result in destabilizing practice expense payments to physicians. Therefore, CMS must evaluate the adequacy of the direct inputs and focus on developing a methodology that captures the average

direct costs of performing a procedure, rather than the direct costs of performing a procedure that represents 51 percent of the patients.

A new methodology is needed based on the best data available so that the direct costs shown in the third column of the table below can be allocated in a manner similar to the allocation of indirect costs. This would result in a PE RVU that is a more accurate reflection of the direct and indirect costs for the resources that are critical to performing the procedure.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC–Determined Estimates

Direct Cost Category	***Included In RUC–Determined Estimate***	***Excluded From RUC–Determined Estimate***
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
Medical Supplies	• Supplies Used For More Than 51% of Patients	• Supplies Used For Less Than 51% of Patients
Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. There are additional improvements that can be made in the manner by which the indirect costs are estimated that are outlined below.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties – Independent Diagnostic Treatment Facilities ("IDTFs"), which account for about two-thirds of the utilization estimate for 93510 TC, and cardiology. The IDTF survey includes a wide range of facilities, but do not reflect the cost profile of cardiac catheterization

facilities--that may have a cost profile similar to cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both (1) the direct costs at the procedure level, and (2) the indirect costs at the practice level.

Solutions

We believe that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization procedures and CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool ("NPWP") has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterization performed in practice or IDTF locations. The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. As a result, we request that CMS freeze payment for these cardiac catheterization-related procedure codes for one year to allow time for a complete assessment of the cost profile of the services listed in the chart provided above.

We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted to CMS to supplement these comments either separately or as part of our comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007. It is our understanding that CMS will accept additional data that helps CMS in evaluating the impact of the PE RVU methodology on our practices.

Sincerely,

R. Dean Hill, MD, FACC
President

RDH:jk

P:\JoAnn\Correspondence\RDH\rdhCMS081706.doc

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

Organization : **private practice**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-1729-Attach-1.DOC

Attach #
1729

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

August 17, 2006

To Whom It May Concern,

I am a licensed clinical social worker (LCSW) in private practice in the state of Tennessee (license number LSW3892), and am writing to express my concerns about a proposal issued in the Federal Register dated June 29, 2006. These proposals seems to recommend that clinical social workers receive a seven percent reduction in work values and a two percent reduction in practice expense values (with a further five percent reduction in practice values to occur in the near future).

These proposed cuts in income will limit my, and I suspect, many others', ability to serve the client population of this practice region due to the financial constraints contained in this recommendation. I would simply have to not see Medicare or Medicaid clients as the cost/benefit ratio, already tenuous for a private practice, would be insupportable.

Therefore I humbly request, both as a service to clinical social work practitioners and the client population you serve, that you not reduce these values as planned for January 1, 2007, that you have funds increased to all Medicare providers, and that you use a different formula than the "bottom up' formula to calculate practice expense.

Thank you for you time and attention.

Respectfully,

Steve Brown LCSW
Licensed Clinical Social Worker
2507 Mineral Springs Ave
Suite C
Knoxville, TN 37917
Tel. (865) 688-0661
Fax (865) 688-5780

Submitter : Dr. Daniel Ruppman

Date: 08/17/2006

Organization : Abbott Northwestern Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the E/M work RVU changes that CMS is proposing. As an internist I have worked both in the outpatient setting and as a hospitalist. The medical complexity of patients has dramatically increased which, in turn, increases the amount of time needed to care for them. If financial constraints are such that physicians cannot spend the time with patients to adequately evaluate their conditions, quality of care will suffer. In addition, we have seen a significant decrease in the interest of medical students and residents in pursuing a career as a general internist. This is due to the significant work involved and the extremely skewed payment system which diverts much of the money away to procedure-oriented and subspecialty areas. With the aging population and increased need for general internists, we will likely be facing a crisis with significant physician shortages and reduced access to care as medical students choose more lucrative areas of medicine. If the proposed changes are accepted, we could see a renewed interest in internal medicine and other areas of primary care. Again, I strongly support these proposed increases.

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

Organization : **NASW CT**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

Please do NOT reduce work values for clinical social work. A 14% cut is significant and will be detrimental to providing services for those in need.
Please withdraw this proposal until funds can increase reimbursement for all Medicare providers, and please do not propose this 'bottom-up'formula. As social workers, we have very little practice expense.

Thank you for your time and attention.

Submitter : Dr. kurt oelke **Date:** 08/17/2006

Organization : Wisconsin Rheumatology Association

Category : Health Care Professional or Association

Issue Areas/Comments

Practice Expense

Practice Expense

see attached

CMS-1512-PN-1732-Attach-1.DOC

A 7-16 ... 1732

August 16, 2006

Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
200 Independence Ave. S.W.
Washington, DC 20201

Dear Dr. McClellan,

In the last four decades there has been tremendous transformation in rheumatology practices. Therapies in the 1960's were based on empirical observation. By 1970 aspirin and gold were used as first and second line therapies respectively in Rheumatoid Arthritis. By the 1980's intense research to understand HIV infection led an understanding of B and T cell function and intracellular communication with cytokine molecules. In the 1990's global research tackled immunologic diseases with an understanding of cellular and immunochemical pathology which clinical rheumatologists, neurologists, oncologists, dermatologists, and gastroenterologists struggle with in their clinics. The new knowledge spawned pharmaceutical development contributing to revolutionary therapies in rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, multiple sclerosis, and inflammatory bowel disease. These therapies are referred to as "biologics" because they are biologically active proteins requiring skilled delivery into the human body. By their nature, biologics will never be orally available because proteins would be denatured in the gastrointestinal tract.

All of these advances come at a cost, and the current proposed practice expense methodology poorly reflects the real expense incurred by rheumatologists. Many rheumatologists must invest in the infrastructure required to administer "infusion " therapy for rheumatoid arthritis patients as do gastroenterologist and dermatologist for Crohn's disease and psoriasis respectively.

Physicians have invested in continuing medical education, additional staff, and equipment to store and administer the new biological therapies. In addition to caring for the patient the physician must acquire additional CME (10-100 dollars/credit hour.) to remain current with infusion immunotherapy which is an evolving therapeutic area. In general at least one additional registered nurse must be hired to deliver biologics. "Biologics" are temperature sensitive and must be shipped and stored under controlled environmental conditions and unused medication must be disposed. Supplies for intravenous therapy must be purchased and maintained. The purchase costs, the cost of which is beyond the means of many practices, are borne by the physicians who administer the biologics in the office. Private payer and Medicare reimbursement for expensive infusions may take as long as 3 months. In the meantime physicians must balance the infusion cost margin and pay billing coordinators to arbitrate with insurance companies who occasionally refuse to pay despite completing intricate prior authorization paperwork. The proposed reduction of the practice expense relative value units (RVU's) are unfair and threaten the financial viability of infusion centers, because the existing coding would result in further underpayment. The demand for rheumatology services

currently exceed the supply and would further jeopardize physician recruitment in a specialty which already is underserved.

We request that reimbursement for infusion therapy be removed from the Practice Expense Methodology and recalculated by a more equitable and accurate process. A failure to rectify these problems will shift infusion therapy from the doctors' office to hospital based centers where ironically Medicare reimburses infusion therapy at a much higher rate. The planned cuts will result in millions of patients losing access to life altering therapy, and fewer rheumatology providers without actually saving Medicare money as hospital payments will rise in excess of anticipated savings.

In summary we ask that CMS exclude chemotherapy administration codes from the bottom-up calculation practice expense RVU's until this methodology can be modified to accurately reflect the direct and indirect costs (i.e. pharmacy management costs) of infusion therapy in the rheumatology office. At a minimum, the proposed methodology should limited to no more than a 50 percent blend of practice expense RVU's calculated using the current methodology and 50 percent of RVU's calculated using the bottom-up methodology until indirect practice expense data are updated. In the interim a potential fix could include Medicare reimbursement for CPT codes 99358 and 99359, prolonged physician service without direct (face-to-face) patient contact for chemotherapy patients. These codes are not currently covered by Medicare. Providing fair coverage for infusion therapy is vital to preserve "state of the art" therapy.

Submitter : **Mr. Shannon Doyle** **Date: 08/17/2006**

Organization : **Penrad Imaging**

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

The proposed cuts in DEXA and Stereotactic Biopsies will make it difficult to continue to offer those services to Medicare patients. You cannot expect us to perform services at below cost.

Submitter : **Dr. Robyn Phillips-Madson** **Date: 08/17/2006**

Organization : **Lake Forest Park Medical Clinic**

Category : **Health Care Provider/Association**

Issue Areas/Comments

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

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

Proposed reductions in technical reimbursement and the professional component for DXA (CPT 76075)will reduce patient access to osteoporosis screening. If these reductions were implemented, our clinic could not cover expenses required for the DXA equipment and
technician. Access to an in-house DXA has improved quality of care, and has been invaluable in the diagnosis and treatment of osteoporosis both in women and men.
We are requesting that you re-evaluate your calculations and reflect
the differences between the old pencil-beam technology versus what is
used today- the fan-beam technology. Up-to-date, state-of-the-art
osteoporosis screening costs must be used to estimate Medicare reimbursement.
Thank you for your reconsideration of this important issue.
Sincerely,

Robyn Phillips-Madson DO
Medical Director
Lake Forest Park Medical Clinic
(a six provider family practice clinic)
17191 Bothell Way NE #205
Lake Forest Park, WA 98155
206-364-8272
fax 206-364-5418

Submitter : **Dr. Johnson** **Date: 08/17/2006**

Organization : **Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a new anesthesiologist. Medicare already pays us pennies on the dollar for our work and to further decrease our compensation is not a good idea. THere is already a shortage of providers and further decfreasing our pay will enlarge that shortage and make access to medical care more difficult particularly in rural and underserved areas

Submitter : **Mr. Greg Kaumeyer** **Date: 08/17/2006**

Organization : **Physical Therapy and Sports Injury Rehabilitation**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1736-Attach-1.DOC

CMS-1512-PN-1736-Attach-2.TXT

A-HACH77
1736

PTSIR

PHYSICAL THERAPY AND SPORTS INJURY REHABILITATION
1816 WEST 170TH STREET, HAZEL CREST, IL 60429

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

Subject: 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:

I am a physical therapist in private practice for 21 years in Illinois. I would like to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units and revisions in the methodology for calculating practice expense RVUs under the Medicare physician fee schedule. I urge CMS to avoid severe Medicare payment cuts for physical therapists and other health care professionals in 2007. I would 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, especially physical therapy.

Under current law, the "Sustainable Growth Rate" (SGR) formula is projected to trigger a 4.6% cut in payments in 2007. These cuts are 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 policies that pile cuts on top of cuts to only a limited group of health care practitioners.

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

The reduction of physical therapy services provided by physical therapists continues to compromise care to patients. Physicians in Illinois are increasing their provision of "physical therapy" by non-trained professionals. While this has been addressed by CMS to require only physical therapists to provide physical therapy, the practice of using non-skilled technicians to provide "physical therapy' incident to a physicians care is proliferating in Illinois. Unfortunately, this occurs to commercial insurance patients and Medicare patients as the physician offices do not differentiate between patients. It is even more frustrating that insurance carriers in the state of Illinois pay 33% more for "physical

therapy" services provided in physician offices by non-skilled technicians, than they do for physical therapy services provided by Physical Therapists. While these concerns should not directly affect Medicare patients, they unfortunate do since many physicians control the referral process of patients and Medicare patients are seen in physician owned clinics that have a physical therapist signing for technician treatment. This is most apparent in the OIG study that noted that 91% of physical therapy billed by physicians and allowed by Medicare during the first 6 months of 2002 did not meet program requirements, resulting in $136 million in improper payments.

I would encourage CMS to value all services provided to Medicare patients equally and lead the insurance industry in requiring high quality, well documented physical therapy services provided by physical therapists.

Thank you for taking time to consider my comments.

Sincerely,

Greg Kaumeyer, M.P.T.

Submitter : **Kate O'Brien** **Date: 08/17/2006**

Organization : **Clinical Social Work Association**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in Seattle, Washington,and a member of the Clinical Social Work Association. I am writing to comment on the proposed CMS cuts to reimbursement rates as proposed in CMS-1512-PN. Clinical social workers, who provide 41% of the nation s mental health services (CSWF, 2005), are often the only mental health clinicians available to our nation s elderly. I am concerned about the impact these cuts will have on my ability to provide services to Medicare enrollees. Social workers are reimbursed at a level that is 25% lower than the rate for psychologists for the same codes. This has always seemed unfair, since the same codes mean the same kinds of services are being provided. However, lowering the reimbursement rates further, as the 14% proposed cuts would, would make it impossible for me to cover my business expenses and, therefore, would make it difficult to serve Medicare enrollees.

I would appreciate your withdrawing the current proposed cuts in reimbursement to LCSW mental health providers. In addition, I hope you will consider changing the inequitable reimbursement system that currently exists, and implement equal pay for equal codes.

Submitter : **Dr. Shraddha Talati** **Date: 08/17/2006**

Organization : **S. Talati M.D.P.A**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1738-Attach-1.DOC

Attach# 1738

S. Talati M.D. P.A.
Obstetrics & Gynecology
Center for Women's health

3500 East I-30, STE E-101
Mesquite, Texas 75150
972-270-8777

www.medicalmap.net

August 17, 2006

Centers for Medicare and Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1512-PN
Mail Stop C4-26-05, 7500
Security Boulevard,
Baltimore, MD 21244-1850

To Whom It May Concern:

There have been errors regarding operating costs and utilization of DXA systems. For Example, the assumption regarding equipment cost of DXA is calculated utilizing cost information using pencil beam technology, whereas virtually all systems utilized today are fan beam. The result is a serious underestimation of the actual costs of providing state of the art osteoporosis screening. The cuts in DXA reimbursement as proposed will negatively impact women's access to this important test.

Sincerely,

S. Talati M.D

Submitter : **Mr. Thomas Spray** **Date: 08/17/2006**

Organization : **360 Physical Therapy and Aquatic Centers**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

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

Subject: Medicare Program: 5 year Review of Work Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology.

Dr. McClellan,
I am currently a physical therapist working as a director at an outpatient facility in a private practice clinic in Sun Lakes, AZ. I have been a physical therapist for almost three years. I would like to offer my comments on the proposed notice to revise the work relative value units (RVU) and the methodology for calculating practice expenses under the Medicare physician fee schedule. This was proposed June 29th.

Under this new proposed revision the RVUs for evaluation/management (E/M) codes would be increased. In order to offset these increased RVUs and achieve neutrality, the work values for all other services billed under the fee billed under the fee schedule will be decreased by 10% in 2007 alone. These changes in work values will significantly hinder my ability as a physical therapist to give my patients the best possible treatment. Under these new revisions, physicians who can bill for E/M codes will see an increase in reimbursement for this code, thus offsetting the decrease in reimbursement under the fee schedule. As a physical therapist, I am not able to bill under the E/M code and therefore will only see a decrease in reimbursement if this proposed revision goes into effect. The fee schedule set into place right now affects many different types of healthcare providers and gives physicians, physical therapists, skilled nursing facilities, and home health agencies the ability to be reimbursed fairly and effectively for all types of services provided by the above healthcare providers. With this proposed revision, all healthcare providers listed above, except for physicians, will be negatively affected.

With this new proposed revision to the RVUs, physicians will see an increase in their reimbursement for E/M codes in order to better treat their patients, and therefore see improved outcomes with patients. However, our healthcare system today is not designed to have one single healthcare professional only for each patient. We have shifted to a team approach in the past few years, making overall outcomes for all patients better. With this proposed change in reimbursement, the values of services provided by non-physician Medicare providers seems to be dismissed, indicating that the only healthcare provider helpful to Medicare patients is the physician. In order for the physician to see the best outcomes for his or her patients, he needs to be able to use a team approach and know that his/her patients will get the best treatment from other healthcare providers, including physical therapists. Under this new proposed revision, the hard work our entire healthcare system has done over the past few years will have little benefit for our patients.

In addition to the proposed revision to work relative value units, physical therapists are also subject to a significant decrease in reimbursement over the next year due to the Sustainable Growth Rate, or SGR. The projected cut for 2007 is 4.6%, and it is projected to total 37% in cuts by 2015. To combine the cuts that will occur due to SGR and additionally have the proposed 10% cut from the revision of work relative value units will cause 2007 to be a very difficult year for all physical therapists, with all physical therapists throughout the United States seeing a devastating decrease in reimbursement.

I would like to thank you for taking the time to read and consider all of the comments made above. Please feel free to contact me at any time with questions or comments.

Sincerely,
Thomas Spray, PT
360 Physical Therapy
480-883-6743

Submitter : **Ms. Joan Loeken** **Date: 08/18/2006**

Organization : **Ms. Joan Loeken**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Practice Expense

Practice Expense

I am a licensed clinical social worker and member of the Clinical Social Work Association.I would appreciate your withdrawing the current proposed cuts in reimbursement to LCSW mental health providers. These proposed cuts are in CMS-1512-PN. Social workers provide 41% of the nation's mental health services and are often the only clinicians available to our nation's elderly. Social workers are reimbursed at a level that is 25% lower than the rate for psychologists for the same codes of service. This is unfair, since the same codes mean the same kinds of services are being provided. Lowering the reimbursement rates further, as the 14% proposed cuts would, would make it difficult for social workers to continue to provide their services. Further, I would hope you will consider changing the inequitable reimbursement system that currently exists, and implement equal pay for equal codes. Thank you. Joan Loeken, LICSW

Submitter : Nancy Kikuchi **Date:** 08/18/2006

Organization : Nancy Kikuchi

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

A 14 percent reimbursement cut will make it impossible for me to continue to see Medicare clients. I urge you to not reduce work values for clinical social workers effective January 1, 2007;
that you withdraw the proposed increase in evaluation and management codes until there are funds to increase reimbursement for all Medicare providers; and that you not approve the proposed 'bottom up' formula to calculate practice expense. I urget you to select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Submitter : Ms. denise smith
Organization : self employed
Date: 08/18/2006
Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

please maintain the intregity of the field and the service reimbursement which reflects such.

Submitter : **Mr. Michael Ruck** **Date: 08/18/2006**

Organization : **Michael A. Ruck, ACSW, LCSW**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

I am expressing my concern regarding the proposed cuts in social work provider and other health care provider reimbursements, as proposed under CMS-1512-PN .

Certainly the cost of medical care is creating increasing disparity between those that have medical coverage and can afford it and those that do not. Decreasing payments to providers that offer alternatives to higher cost treatments does not appear to be a rational solution and I encourage out legislators to reconsider any actions that would create blocks to getting served by providers that offer the most cost-effective service, i.e; social workers in home health and psychotherapy vs. nursing homes and long-term psychiatric medication management.

Submitter : Mrs. Cindy Reese **Date:** 08/18/2006

Organization : Osteoporosis Ctr. of Denton

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

DXA Scanning. Includes performing Spine & Hip scan (2 scans),providing pt.education material,nutrition information,importance of exercise,lifestyle changes to assist in healthier life. These are all included in DXA testing. Total time to perform DXA = 30 mins. (8 mins. for questionaire/insurance info) 22 mins. include review of questionaire, suggestions for nutritional changes & dietary supplements,exercise advice/consultation,answer pt. questions pertaining to bone health & lifestyle changes,positioning/performing scan @ 2 sites in order to assure accuracy in results, manually analyzing scan to assure accuracy in results,printing & assembling scan data to transfer to physician for interpretation. The above are included in "performing DXA scan" therefore the units of time = 30 mins.

Submitter : **Ms. Shannon McDowell** **Date: 08/18/2006**

Organization : **Aquatic Health and Rehab**

Category : **Physical Therapist**

Issue Areas/Comments

Practice Expense

Practice Expense

See Attachment

CMS-1512-PN-1746-Attach-1.WPD

1746

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

August 18, 2006

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

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

Dear Dr. McClellan;

My name is Shannon McDowell; I am a physical therapist with Aquatic Health and Rehabilitation Services, Inc. in Merritt Island and Cocoa Beach, FL. I am a graduate of the University of Central Florida, and have been practicing PT for Less than 1 year.

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

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

I am making the above recommendations for the following reasons:

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

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

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

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

Sincerely,

Terry Shepherd, PT, MSHA

CMS-1512-PN-1747 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Dr. Shenin Sachedina** **Date & Time:** **08/18/2006**

Organization : **Central Florida Breast Center, PA**

Category : **Physician**

Issue Areas/Comments

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

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

August 18, 2006

Central Florida Breast Center, PA
1925 Mizell Ave., Suite 105
Winter Park, FL 32792

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

RE: CMS-1512-PN

CPT Codes 76082 and 76083

We recommend that CMS withdraw its proposed reduction for the technical component of CAD until such time that providers can differentiate between the 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 .

These revisions reflect changes in medical practice, coding changes, new data on relative value components, and the addition of new procedures that affect the relative amount of physician work required to perform each service as required by statute. There
Have been no changes to substantiate this proposed rule for the use of CAD with analog mammography.

Sincerely,

Shenin Sachedina, DO

Central Florida Breast Center
407-740-5127

CMS-1512-PN-1748 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Mr. Charles Furr** **Date & Time:** **08/18/2006**

Organization : **MedCath Diagnostics, LLC**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1748-Attach-1.DOC

CMS-1512-PN-1748-Attach-2.DOC

CMS-1512-PN-1748-Attach-3.DOC

CMS-1512-PN-1748-Attach-4.TXT

CMS-1512-PN-1748-Attach-5.PDF

CMS-1512-PN-1748-Attach-6.PDF

CMS-1512-PN-1748-Attach-7.PDF

Attach #
1748

MedCath®
Diagnostics, LLC

August 18, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (June 29, 2006); Comments re: Practice Expense

Dear Dr. McClellan:

On behalf of MedCath Diagnostics, LLC and our 65 affiliated individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

MedCath Diagnostics, LLC, a subsidiary of MedCath Corporation, owns and operates four outpatient cardiac catheterization labs located in North Carolina and Arizona. These facilities are certified by Medicare as IDTFs. Collectively, these facilities perform approximately 2800 outpatient cardiac catheterization facilities each year.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact of the proposed methodology o n procedures with significant TC costs because they share the same problems that we will outline below. We also believe that the same solution should be applied to all of the procedures listed below.

With regard to catheterizations, the proposed change in PE RVUs would result in a 53.1 percent reduction of payments for CPT 93510 TC. Similarly, payment for two related codes—93555 TC and 93556 TC would be reduced substantially. In fact, under the Medicare Physician Fee Schedule ("PFS"), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate for these three codes to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	Description
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom up micro-costing approach is laudable and consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comport with the statutory requirement that would match resources to payments. After reviewing the proposed methodology, including the 19 step calculation, we have identified several flaws that result in the PE RVU underestimating the resources needed to provide the technical component of cardiac catheterizations. We will address our concerns with the calculation of direct costs and indirect costs separately, as set forth below.

Direct Costs

The estimate of direct costs is critical for the first step in calculating the PE RVU for each procedure code. The direct costs are based on inputs from the American Medical Association's RVS Update Committee ("RUC") and reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. The RUC-determined direct costs do not reflect estimates of additional labor, supply and equipment costs that were submitted by (The Society for Cardiovascular Angiography and Interventions ("SCAI") or an industry group). As a result, the RUC-determined cost estimate is about half of the estimate that would result if all of the data were included. The addition of these additional costs which are consistent with the RUC protocol would increase the proposed PE RVUs by 24 percent.

Even if the RUC estimates included the additional costs submitted by SCAI or an industry group, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns. For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients. Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

Unless the RUC considers the actual costs of the clinical labor, supply and equipment used to perform a cardiac catheterization, the PE RVU that results at the end of the 19 step calculation will never reflect the actual resources needed to perform the procedure and will result in destabilizing practice expense payments to physicians. Therefore, CMS must evaluate the adequacy of the direct inputs and focus on developing a methodology that captures the average direct costs of performing a procedure, rather than the direct costs of performing a procedure that represents 51 percent of the patients.

A new methodology is needed based on the best data available so that the direct costs shown in the third column of the table below can be allocated in a manner similar to the allocation of indirect costs. This would result in a PE RVU that is a more accurate reflection of the direct and indirect costs for the resources that are critical to performing the procedure.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC–Determined Estimates

Direct Cost Category	***Included In RUC–Determined Estimate***	***Excluded From RUC–Determined Estimate***
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
Medical Supplies	• Supplies Used For More Than 51% of Patients	• Supplies Used For Less Than 51% of Patients
Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. There are additional improvements that can be made in the manner by which the indirect costs are estimated that are outlined below.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties – Independent Diagnostic Treatment Facilities ("IDTFs"), which account for about two-thirds of the utilization estimate for 93510 TC, and cardiology. The IDTF survey includes a wide range of facilities, but do not reflect the cost profile of cardiac catheterization facilities--that may have a cost profile similar to cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both (1) the direct costs at the procedure level, and (2) the indirect costs at the practice level.

Solutions

We believe that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization procedures and CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool ("NPWP") has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterization performed in practice or IDTF locations. The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. As a result, we request that CMS freeze payment for these cardiac catheterization-related procedure codes for one year to allow time for a complete assessment of the cost profile of the services listed in the chart provided above.

We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted to CMS to supplement these comments either separately or as part of our comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007. It is our understanding that CMS will accept additional data that helps CMS in evaluating the impact of the PE RVU methodology on our practices.

Sincerely,

Charles F. Furr, Jr. CHE

President

CMS-1512-PN-1749 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Mr. Stephen Mandel **Date & Time:** 08/18/2006

Organization : Mr. Stephen Mandel

Category : Individual

Issue Areas/Comments

Practice Expense

Practice Expense

Clinical social workers, who provide 41% of the nation s mental health services (CSWF, 2005), are often the only mental health clinicians available to our nation s elderly. I am concerned about the impact these cuts will have on clinical social workers ability to continue to provide services to Medicare enrollees.
Clinical social workers see most Medicare enrollees under Current Procedural Terminology (CPT) Code 90806, but are reimbursed at a level that is 25% lower than the rate for psychologists for the same codes. This is unfair, since the same codes mean the same kinds of services are being provided. However, lowering the reimbursement rates further, as the 14% proposed cuts would, would make it impossible for clinical social workers to cover business expenses and, therefore, would make it difficult to continue serving Medicare enrollees.
I would appreciate your withdrawing the current proposed cuts in reimbursement to LCSW mental health providers. In addition, I hope you will consider changing the inequitable reimbursement system that currently exists, and implement equal pay for equal codes.

CMS-1512-PN-1750 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Dr. Paul Caldron** **Date & Time:** **08/18/2006**

Organization : **Arizona Arthritis and Rheumatology Associates, PC**

Category : **Physician**

Issue Areas/Comments

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

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

The Centers for Medicare & Medicaid Services (CMS) recently proposed regulations that will dramatically reduce reimbursement for the performance of DXA (CPT code 76075) from the current ~$140 to ~$40 by 2010 and VFA (CPT code 76077) from the current ~$40 to ~$25. These cuts would be in addition to the already-enacted imaging cuts in the Deficit Reduction Act of 2005. It is extremely likely that this regulatory change in the Medicare Physician Fee Schedule will markedly reduce the availability of high quality bone density measurement, with a consequent decline in quality osteoporosis care.

Already, we, the largest rheumatology group in the southwest, are delaying decisions about upgrading our technology. There is no question of the favorable impact of densitometry on the inexorable ravages of osteoporosis among American women and others at risk. Please do not allow such backtracking in clinical success.

CMS-1512-PN-1751 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Mrs. MARGARET COOMBS **Date & Time:** 08/18/2006

Organization : KINSTON OB-GYN ASSO, PA

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider the changes to the Medicare Physicain Fee Schedule (CMS-1512-PN, RIN 0938-A012,Medicare Prgram:) that would reduce the reimbursement for (cpt 76075). This reduction in fees would greatly reudce the number of women that could be diagnosed with osteoporosis and other diseases diagnosed by this procedure.

CMS-1512-PN-1752 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Ms. Susan Bienvenu** **Date & Time:** **08/18/2006**

Organization : **Self, as a practitioner**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

My comment is in regard to the 14 percent reimbursement rate cut being levied on clinical social workers. This will affect not only the social workers, but the patients who rely on them. Decreasing reimbursement rates causes practitioners to limit their Medicare caseloads and in effect, creates a barrier to service for the patient. Medicare is designed to provide the needed services, not to deny them.
Please do not reduce work values for clinical social workers effective January 1, 2007. Please withdraw the proposed increase in evaluation and management codes until such time that there are funds to increase reimbursement for all Medicare providers. Please do not to approve the proposed "bottom up" formula to calculate practice expense, in fact, please select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.
The field of social work is integral to the health and well-being of our most vulnerable citizens. As such, this function can actually REDUCE medical costs due to the social worker's capcity to ensure that appropriate level of care is delivered to the patient at the right time. In some cases, this may mean reduction of costs through realistic review of prognosis and reduction in care. In other cases, it may mean a short-term intervention that provides the circumstances for a patient to discharge from a facility and return to the community safely.
Reducing reimbursement rates will likely result in further loss of social work input in these situations. This loss of expertise will hurt the patients, cause more unnecessary costs to the third party payer and likely diminished quality of care.
Please reconsider cutting the reimbursement rates that unfairly target clinical social workers and their clients. The clients need the social workers, but the social workers can only provide the assistance if they can also keep their practice viable.

CMS-1512-PN-1753 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Date & Time: 08/18/2006**

Organization :

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

If this proposal should be put into action, I would have to stop performing DXA scans in my office. This would be a very big inconvience for my patients which the majority are over 50 years of age. It just would not be feesable for me to only be reimbursed $40 per scan and still be able to perform the routine maintence that must be done to keep the machine in good working condition. Not only that, there is no way I could pay for my technician to come in and perform the scans. This is not only going to hurt me, but my patient are very upset about this proposal stating they do not want to have to go & have this done at the hospital. They enjoy being able to come to a familiar place for their testing needs.

Submitter : **Dr. Mark Ostahowski** **Date: 08/18/2006**

Organization : **Midland Family Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

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

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

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

CMS-1512-PN-1755 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Tanya Mayfield** **Date & Time:** **08/18/2006**

Organization : **Tanya Mayfield**

Category : **Social Worker**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

This comment is in response to the proposed notice on the Physician Fee Schedule, which addresses the RVU (work) and the Practice Expense values, which affects clinical social workers (file code: CMS-1512-PN).

A 14 percent decrease in reimbursement will affect clinical social workers practice as a Medicare provider. I am requesting CMS to reconsider reducing work values for clinical social workers effective January 1, 2007. Withdrawal of the proposed increase in evaluation and management codes until the funds needed to increase reimbursement for all Medicare providers are available is critical. CMS should not approve the proposed bottom up formula to calculate practice expense and should select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Submitter : **Mrs. Patricia Wright** **Date: 08/18/2006**

Organization : **Orlando Cardiovascular Center**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Practice Expense

Practice Expense

See Attachment

CMS-1512-PN-1756-Attach-1.DOC

H77CU1H
1756

August 18, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (June 29, 2006); Comments re: Practice Expense

Dear Mr. McClellan:

On behalf of the Orlando Cardiovascular Center and our twenty-five individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

The Orlando Cardiovascular Center is a freestanding cardiac catheterization facility located in Orlando, Florida. We are classified as and IDTF by CMS. The Orlando Cardiovascular Center has twenty-five physicians from three different cardiology practices and has been providing catheterization services since 1991. The facility currently performs approximately one thousand procedures per year and has performed over eleven thousand procedures since opening.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact of the proposed methodology on procedures with significant TC costs because they share the same problems that we will outline below. We also believe that the same solution should be applied to all of the procedures listed below.

With regard to catheterizations, the proposed change in PE RVUs would result in a 53.1 percent reduction of payments for CPT 93510 TC. Similarly, payment for two related codes—93555 TC and 93556 TC would be reduced substantially. In fact, under the Medicare Physician Fee Schedule ("PFS"), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate for these three codes to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	Description
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom up micro-costing approach is laudable and consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comport with the statutory requirement that would match resources to payments. After reviewing the proposed methodology, including the 19 step calculation, we have identified several flaws that result in the PE RVU underestimating the resources needed to provide the technical component of cardiac catheterizations. We will address our concerns with the calculation of direct costs and indirect costs separately, as set forth below.

Direct Costs

The estimate of direct costs is critical for the first step in calculating the PE RVU for each procedure code. The direct costs are based on inputs from the American Medical Association's RVS Update Committee ("RUC") and reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. The RUC-determined direct costs do not reflect estimates of additional labor, supply and equipment costs that were submitted by (The Society for Cardiovascular Angiography and Interventions ("SCAI") or an industry group). As a result, the RUC-determined cost estimate is about half of the estimate that would result if all of the data were included. The addition of these additional costs which are consistent with the RUC protocol would increase the proposed PE RVUs by 24 percent.

Even if the RUC estimates included the additional costs submitted by SCAI or an industry group, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns. For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients. Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

Unless the RUC considers the actual costs of the clinical labor, supply and equipment used to perform a cardiac catheterization, the PE RVU that results at the end of the 19 step calculation will never reflect the actual resources needed to perform the procedure and will result in destabilizing practice expense payments to physicians. Therefore, CMS must evaluate the adequacy of the direct inputs and focus on developing a methodology that captures the average direct costs of performing a procedure, rather than the direct costs of performing a procedure that represents 51 percent of the patients.

A new methodology is needed based on the best data available so that the direct costs shown in the third column of the table below can be allocated in a manner similar to the allocation of indirect costs. This would result in a PE RVU that is a more accurate reflection of the direct and indirect costs for the resources that are critical to performing the procedure.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC–Determined Estimates

Direct Cost Category	***Included In RUC–Determined Estimate***	***Excluded From RUC–Determined Estimate***
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
Medical Supplies	• Supplies Used For More Than 51% of Patients	• Supplies Used For Less Than 51% of Patients
Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. There are additional improvements that can be made in the manner by which the indirect costs are estimated that are outlined below.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties – Independent Diagnostic Treatment Facilities ("IDTFs"), which account for about two-thirds of the utilization estimate for 93510 TC, and cardiology. The IDTF survey includes a wide range of facilities, but do not reflect the cost profile of cardiac catheterization facilities--that may have a cost profile similar to cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both (1) the direct costs at the procedure level, and (2) the indirect costs at the practice level.

Solutions

We believe that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization procedures and CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool ("NPWP") has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterization performed in practice or IDTF locations. The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. As a result, we request that CMS freeze payment for these cardiac catheterization-related procedure codes for one year to allow time for a complete assessment of the cost profile of the services listed in the chart provided above.

We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted to CMS to supplement these comments either separately or as part of our comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007. It is our understanding that CMS will accept additional data that helps CMS in evaluating the impact of the PE RVU methodology on our practices.

Sincerely,

Patricia A. Wright
Executive Director

Cc: Irwin R. Weinstein, M.D.
Steve Blades, COCA

Submitter : **Mrs. Patricia Wright** **Date: 08/18/2006**

Organization : **Orlando Cardiovascular Center**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Practice Expense

Practice Expense

See Attachment

CMS-1512-PN-1756-Attach-1.DOC

Attach# 1756

August 18, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (June 29, 2006); Comments re: Practice Expense

Dear Mr. McClellan:

On behalf of the Orlando Cardiovascular Center and our twenty-five individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

The Orlando Cardiovascular Center is a freestanding cardiac catheterization facility located in Orlando, Florida. We are classified as and IDTF by CMS. The Orlando Cardiovascular Center has twenty-five physicians from three different cardiology practices and has been providing catheterization services since 1991. The facility currently performs approximately one thousand procedures per year and has performed over eleven thousand procedures since opening.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact of the proposed methodology o n procedures with significant TC costs because they share the same problems that we will outline below. We also believe that the same solution should be applied to all of the procedures listed below.

With regard to catheterizations, the proposed change in PE RVUs would result in a 53.1 percent reduction of payments for CPT 93510 TC. Similarly, payment for two related codes—93555 TC and 93556 TC would be reduced substantially. In fact, under the Medicare Physician Fee Schedule ("PFS"), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate for these three codes to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	Description
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom up micro-costing approach is laudable and consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comport with the statutory requirement that would match resources to payments. After reviewing the proposed methodology, including the 19 step calculation, we have identified several flaws that result in the PE RVU underestimating the resources needed to provide the technical component of cardiac catheterizations. We will address our concerns with the calculation of direct costs and indirect costs separately, as set forth below.

Direct Costs

The estimate of direct costs is critical for the first step in calculating the PE RVU for each procedure code. The direct costs are based on inputs from the American Medical Association's RVS Update Committee ("RUC") and reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. The RUC-determined direct costs do not reflect estimates of additional labor, supply and equipment costs that were submitted by (The Society for Cardiovascular Angiography and Interventions ("SCAI") or an industry group). As a result, the RUC-determined cost estimate is about half of the estimate that would result if all of the data were included. The addition of these additional costs which are consistent with the RUC protocol would increase the proposed PE RVUs by 24 percent.

Even if the RUC estimates included the additional costs submitted by SCAI or an industry group, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns. For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients. Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

Unless the RUC considers the actual costs of the clinical labor, supply and equipment used to perform a cardiac catheterization, the PE RVU that results at the end of the 19 step calculation will never reflect the actual resources needed to perform the procedure and will result in destabilizing practice expense payments to physicians. Therefore, CMS must evaluate the adequacy of the direct inputs and focus on developing a methodology that captures the average direct costs of performing a procedure, rather than the direct costs of performing a procedure that represents 51 percent of the patients.

A new methodology is needed based on the best data available so that the direct costs shown in the third column of the table below can be allocated in a manner similar to the allocation of indirect costs. This would result in a PE RVU that is a more accurate reflection of the direct and indirect costs for the resources that are critical to performing the procedure.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC–Determined Estimates

Direct Cost Category	***Included In RUC–Determined Estimate***	***Excluded From RUC–Determined Estimate***
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
Medical Supplies	• Supplies Used For More Than 51% of Patients	• Supplies Used For Less Than 51% of Patients
Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. There are additional improvements that can be made in the manner by which the indirect costs are estimated that are outlined below.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties – Independent Diagnostic Treatment Facilities ("IDTFs"), which account for about two-thirds of the utilization estimate for 93510 TC, and cardiology. The IDTF survey includes a wide range of facilities, but do not reflect the cost profile of cardiac catheterization facilities--that may have a cost profile similar to cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both (1) the direct costs at the procedure level, and (2) the indirect costs at the practice level.

Solutions

We believe that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization procedures and CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool ("NPWP") has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterization performed in practice or IDTF locations. The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. As a result, we request that CMS freeze payment for these cardiac catheterization-related procedure codes for one year to allow time for a complete assessment of the cost profile of the services listed in the chart provided above.

We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted to CMS to supplement these comments either separately or as part of our comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007. It is our understanding that CMS will accept additional data that helps CMS in evaluating the impact of the PE RVU methodology on our practices.

Sincerely,

Patricia A. Wright
Executive Director

Cc: Irwin R. Weinstein, M.D.
Steve Blades, COCA

Submitter : **Dr. Leonard Wartofsky** **Date: 08/18/2006**

Organization : **The Endocrine Society**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

The Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8014

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

Dear Administrator McClellan:

On behalf of The Endocrine Society (Society), representing more than 13,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to the payment policies under the Physician Fee Schedule for calendar year 2007. The Society looks forward to working closely with the Agency as this proposed rule moves toward implementation.

Founded in 1916, our Society represents physicians and scientists engaged in treatment and research of endocrine disorders, such as osteoporosis, diabetes, infertility, obesity, and thyroid disease. Our primary and most significant issue of concern with the Physician Fee Schedule proposed rule relates to procedures used to help diagnose and treat osteoporosis. Although the Society greatly appreciates and applauds the Agency's work in accurately and equitably valuing Evaluation and Management (E/M) Services, we are very concerned with the proposal put forward by CMS to drastically cut payment for DXA (Dual Energy X-Ray Absorptiometry) & VFA (Vertebral Fracture Assessment). Furthermore, we believe such a proposed policy will have negative and unintended consequences for the more than 10 million Americans with osteoporosis and the 34 million at risk for fractures due to low bone mass (osteopenia). The Society's comments address the following areas:

1) Osteoporosis Patient Care and Access to DXA & VFA
2) Methodology Used to Calculate Practice Expense for DXA & VFA
3) Physician Work RVU Component for DXA.

Osteoporosis is a major health care issue in the United States costing more than $18 billion annually DXA and VFA are crucial for the detection of osteoporosis and identification of those at highest fracture risk before a fracture occurs. Federal initiatives to identify patients with osteoporosis have led to the increased utilization of DXA and VFA; however, the vast majority of affected individuals continue to remain undiagnosed and untreated.

The Society is concerned that the proposed changes in the physician fee schedule would reduce DXA reimbursement from approximately $140 to $40 and VFA from $40 to $25. These reductions will force physicians to discontinue offering these vital services, resulting in a severe limitation of patient access to quality bone densitometry and vertebral fracture assessment. There appear to be flaws in data input and data omission (inappropriate application of equipment cost, inappropriate utilization rates, and omission of other densitometry costs), which combined with use of other CMS methodology for calculation of the practice expense, results in these severe cuts in DXA and VFA reimbursement. For these reasons, TES respectfully requests that CMS:

1) Examine the data, consult with affected specialty organizations, and explain the rationale for these proposed cuts; and

2) Refrain from making any changes to the current total RVU for DXA (CPT code 76075) and VFA (CPT code 76077).

Significant and Disproportionate Cuts in Reimbursement
The full impact of these proposed cuts alone would result in a reimbursement reduction of 71 percent for DXA and 37 percent for VFA by 2010.

Practice Expense

Practice Expense

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

Dear Administrator McClellan:

On behalf of The Endocrine Society (Society), representing more than 13,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to the payment policies under the Physician Fee Schedule for calendar year 2007. The Society looks forward to working closely with the Agency as this proposed rule moves toward implementation.

Founded in 1916, our Society represents physicians and scientists engaged in treatment and research of endocrine disorders, such as osteoporosis, diabetes, infertility, obesity, and thyroid disease. Our primary and most significant issue of concern with the Physician Fee Schedule proposed rule relates to procedures used to help diagnose and treat osteoporosis. Although the Society greatly appreciates and applauds the Agency's work in accurately and equitably valuing Evaluation

and Management (E/M) Services, we are very concerned with the proposal put forward by CMS to drastically cut payment for DXA (Dual Energy X-Ray Absorptiometry) & VFA (Vertebral Fracture Assessment). Furthermore, we believe such a proposed policy will have negative and unintended consequences for the more than 10 million Americans with osteoporosis and the 34 million at risk for fractures due to low bone mass (osteopenia). The Society's comments address the following areas:

1) Osteoporosis Patient Care and Access to DXA & VFA
2) Methodology Used to Calculate Practice Expense for DXA & VFA
3) Physician Work RVU Component for DXA.

Osteoporosis is a major health care issue in the United States costing more than $18 billion annually DXA and VFA are crucial for the detection of osteoporosis and identification of those at highest fracture risk before a fracture occurs. Federal initiatives to identify patients with osteoporosis have led to the increased utilization of DXA and VFA; however, the vast majority of affected individuals continue to remain undiagnosed and untreated.

The Society is concerned that the proposed changes in the physician fee schedule would reduce DXA reimbursement from approximately $140 to $40 and VFA from $40 to $25. These reductions will force physicians to discontinue offering these vital services, resulting in a severe limitation of patient access to quality bone densitometry and vertebral fracture assessment. There appear to be flaws in data input and data omission (inappropriate application of equipment cost, inappropriate utilization rates, and omission of other densitometry costs), which combined with use of other CMS methodology for calculation of the practice expense, results in these severe cuts in DXA and VFA reimbursement. For these reasons, TES respectfully requests that CMS:

1) Examine the data, consult with affected specialty organizations, and explain the rationale for these proposed cuts; and

2) Refrain from making any changes to the current total RVU for DXA (CPT code 76075) and VFA (CPT code 76077).

Significant and Disproportionate Cuts in Reimbursement
The full impact of these proposed cuts alone would result in a reimbursement reduction of 71 percent for DXA and 37 percent for VFA by 2010. The Deficit Reduction Act of 2005 (DRA) included two provisions that significantly reduced Medicare reimbursement for imaging services the first reduced payment for the technical component of the imaging of contiguous body parts in the same imaging session, and the second reduced payment for imaging services performed in a physician's office if the current reimbursement exceeds that of the outpatient fee schedule that was determined by the CMS. As a result of the cuts, reimbursement for DXA bone density scan will be reduced by 40 percent.

CMS-1512-PN-1757-Attach-1.PDF

Submitter : **Mr. Ellis Jackson** **Date: 08/18/2006**

Organization : **American Association of Nurse Anesthetists**

Category : **Nurse Practitioner**

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

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

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

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

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

Submitter : **Mr. Ellis Jackson** **Date: 08/18/2006**

Organization : **American Association of Nurse Anesthetists**

Category : **Nurse Practitioner**

Issue Areas/Comments

Other Issues

Other Issues

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

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

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

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

Submitter : **Dr. Diane Cunningham** **Date: 08/18/2006**

Organization : **Rochester Gynecologic and Obstetric Associates**

Category : **Physician**

Issue Areas/Comments

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

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

I am an OBGYN physician practicing in Rochester NY.

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). 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 the 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,

Diane Cunningham, MD

Submitter : Mrs. Ellen Weiland

Date: 08/18/2006

Organization : Ellen Weiland, LCSW

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I travel approx 100 miles round trip to offer services to Medicare clients who are on disability, without transport, and in an area where there are no Medicare providers accepting Medicare clients. Practice expense as related to income (claims paid by Medicare) make this nearly a voluntary effort on my part. Further reduction of Medicare payments will prompt me to rethink continuing this service.

Submitter : Ms. Kalynn Gillis **Date:** 08/18/2006

Organization : Providence Medford Medical Center

Category : Hospice

Issue Areas/Comments

GENERAL

GENERAL

As a Social Worker in hospice I have very strong feelings about the possibility of a reduction of work values for social work re: CMS 1512-PN. Please know that hospice is struggling to provide care to their patients even now with the rising cost of drugs and new technologies. We are working under very demanding situations where all the support we can get is needed. To cut back on funding would put an increasing burden on the system already stressed. Please withdraw the proposed increase in evalutation and management codes until funds can be secured for increase in Medicare reimbursement to providers. The bottom up approach to calculating practice expense is inapproproriate. Please find a way to address this issue without negative impact on clinical social work who have a very little practice expense as providers. Kalynn Gillis MSW, LCSW