Submitter : Dr. W. Stephen Minore **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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As the policy currently stands, anesthesiologists and other specialties face huge cuts to supplement the overhead cost increases for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses. CMS should gather new overhead expense data to replace the decade-old data currently being used. ASA, many other specialties and the AMS are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. CMS must address the issue of anesthesia work undervaluation of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Submitter : Dr. Maria Laporta **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Norbert Duttlinger **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Steven Gunderson **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Submitter : Dr. Vincent Quinlan **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Douglas Loughead **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. John Shiro **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. John Szewczyk **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Timothy Starck **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Edward Post **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. George Arends **Date:** 08/18/2006

Organization : Rockford Anesthesioloigsts Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Greg Niemer **Date:** 08/18/2006

Organization : South Carolina Rheumatism Society

Category : Health Care Professional or Association

Issue Areas/Comments

Practice Expense

Practice Expense

Dear CMS:
This letter is on behalf of SCRS regarding the proposed changes to DXA and VFA reimbursement that are currently proposed by CMS (1512-PN, 1502-P). As you are well aware, Osteoporosis is a very common disease with an alarming rate of morbibity and mortality. DXA screening is very important for early detection and monitoring for appropriate treatment, and our concern is a cut in reimbursement could have a negative impact on patient access and optimal quality of care. There has been a marked increase in DXA usage over the last 10 tears, which is in line with new medications available combined with Federal initiatives (The Bone Mass Measurement ACT, the US Preventative Task Force, and the Surgeon General's Report on Osteoporosis) which have increased patient awareness of the need for screening. The appropriate use of this tool has led to a significant drop in complications of Osteoporosis, including nursing home costs incurred after a fractured hip or vertebral compression fractue.
Several assumtions were made in recalculating the fee schedule that are questionable. Practice expense was calculated to be approximately $41,000. Most modern DXA machines which are VFA capable are going to cost twice this amount. In addition, rate utilization was calculated to be 50%, which is twice the rate of most non-imaging centers where a large percentage of DXA's and VFA's are performed. In addition, software upgrades and maintenance weren't factored into the equation. There also is a larger work component for physicians that must be considered, as accomodations have to be made for factors that effect automated readings, such as previous fractures and significant degenerative disc disease that can give spuriously high T-score results. There is also significant time required for patient education and communication with other physicians.
DXA and VFA are vital diagnostic tools that are currently being provided by many physicians as a service with the main goal being optimal convenience for the patient and compliance with data - driven recommendations ensuring proper medical management, not based on the hope of financial gain. It is our concern these cuts will have a negative effect on patient access, as proposed reimbursement rates will not cover costs. We hope that CMS will modify the recommendations in order to ensure the high quality of care that we have fortunately been able to realize.
Regards,
Gregory W. Niemer, MD
Chair, Advocacy Commitee
South Carolina Rheumatism Society

Submitter : Dr. Bryan Apple **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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As the policy currently stands, anesthesiologists and other specialties face huge cuts to supplement the overhead cost increases for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses. CMS should gather new overhead expense data to replace the decade-old data currently being used. ASA, many other specialties and the AMS are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. CMS must address the issue of anesthesia work undervaluation of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Submitter : Mr. Ken Taber **Date:** 08/18/2006

Organization : Ken Taber

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I strongly object to the Medicare proposal to reduce payments to clincial social workers. I am an endorsed provider who already accepts a rate too low , yet , continue to accept these clients as I consider them valued citizens who benefit with my asssistance. Please don't allow this to happen.

Ken Taber LMSW, Grand Rapids, MI

Submitter : Dr. Myung-Sang Lee **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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As the policy currently stands, anesthesiologists and other specialties face huge cuts to supplement the overhead cost increases for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses. CMS should gather new overhead expense data to replace the decade-old data currently being used. ASA, many other specialties and the AMS are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. CMS must address the issue of anesthesia work undervaluation of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

Submitter : Dr. John Kallich **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Joe Juarez **Date:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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CMS-1512-PN-1780 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Dr. John Jaworowicz **Date & Time:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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As the policy currently stands, anesthesiologists and other specialties face huge cuts to supplement the overhead cost increases for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses. CMS should gather new overhead expense data to replace the decade-old data currently being used. ASA, many other specialties and the AMS are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. CMS must address the issue of anesthesia work undervaluation of our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinic and throughout critical care medicine.

CMS-1512-PN-1781 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Mr. Richard S **Date & Time:** 08/18/2006

Organization : Mr. Richard S

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

Mark B McClellan, MD, PhD
Centers for Medicare and Medicad Services

Re: Medicare Program: Five-year review...

Dear Dr. McClellan,
I am a Physical Therapist who has been practicing in Washington State, and the territory of Guam for the past 10+ years. In that time I have worked with hundreds of Medicare clients,and have seen the benifit to their function and quality of life by recieving the professional services of PT.

As I hear of more and more medical clinics, both physicians and others, who refuse to see Medicare clients because of current regulations, burocuracy, and exsisting reimbursement rates -- it is of grave concern to consider the effect of the "Sustainable Growth Rate" formula -- effecting projected 4.6% cuts for PT services next year, and likely similar cuts in following years.

This is going to remove more and more providers from the pool of those willing to serve the Medicare population. I could only suspect that of those continuing to provide nessessary PT services, some would be inclined (or required) to abreviate nessessary proceedures, and find other ways to "cut corners", in order to keep their facility afloat.

This can't be good for the Medicare system, nor for our profession, and certainly can't be good for the American people.

In conclusion, I would urge the CMS to take a strong stand to protect the American People, and their rights and need for access to the physical rehabilitation servicies of Physical Therapists. This requires ensuring that the severe Medicare payment cuts to PT (and other health care professionals) do not occur for 2007 and following years.

Thank you for your time and attention.

God bless America,

Richard Schafer, PT
Washington, 98284

CMS-1512-PN-1782 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Dr. John Jaworowicz **Date & Time:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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CMS-1512-PN-1783 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Dr. Susan Mangnsll-Harris **Date & Time:** 08/18/2006

Organization : S. Mangnall-Harris Psy.D., RN, LCSW

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

As an independent Psychotherapy practitioner, I've resisted applying to treat Medicare clients because:
1)Lengthy paperwork application and claim process
2) Exactly the reason of the proposed price reduction for services rendered.
This is too bad as my Cardiac Surgery nursing experience combined with my psychology and social work education makes me an ideal provider for the elderly.

CMS-1512-PN-1784 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Dr. Steven Hryszczuk **Date & Time:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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CMS-1512-PN-1785 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Dr. Rao Gondi **Date & Time:** 08/18/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Mr. Lee S Broadston **Date:** 08/18/2006

Organization : BCS, Incorporated

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1786-Attach-1.DOC

Attachment
1786

Memorandum

TO: **Centers for Medicare & Medicaid Services**
Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Bldg
200 Independence Ave., SW
Washington, DC 20201

FROM: **Lee S. Broadston**
Anesthesia Healthcare Practice Consultant
BCS, Incorporated

ATTN: CMS-1512-PN

Re: Comments on Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (71 Fed. Reg. 37170, June 29, 2006).

EVALUATION AND MANAGEMENT

To Whom It May Concern;

If I look at one inner city-urban multi-site health system CRNA anesthesia practice that my organization manages, and consider the reimbursement from Medicare for CRNA services to drop by 10% I must also take into account Tri-Care, FEP-Federal Employee Programs, and all of the various HMO/Managed care Medicare programs and the managed care Medicaid programs that have fee schedules based fully or in part on the Medicare conversion factor. In doing so, I see decreases across multiple payers of the practice. In this typical inner city health system we will see overall actual cash reductions of $270,000 to $300,000 per year in CRNA reimbursement. This consists of Medicare reductions plus those fee schedules for Medicare and Medicaid HMO products that are based upon the Medicare fee schedule, including Tri-Care and FEP. This could easily result in the layoff of two to three CRNAs, which would essentially close down the same number of operating rooms in this one health system alone. This urban practice I am using as an example is one of many in this particular urban environment –i.e. 6 prominent health systems in all- equates to the potential closure or reduction in access to healthcare services of 15 - 20 operating rooms. Multiply this by the total number of large urban areas we have across the nation – i.e. LA, Atlanta, Dallas, Phoenix, Detroit, Seattle, St. Louis, Miami, Boston, and New York City, we could easily see a closure of 150 - 200 operating rooms. I realize this example is crude and I have moved through the data quickly to make my point, but this is the impact. Additionally,

this may also increase the pressure of identifying an alternative provider of anesthesia services in all or certain procedures involving anesthesia services. Allowing economic pressures such as this to dictate the actual administrator of anesthesia services –whether or not to use a fully trained and accredited qualified anesthetist as outlined in CMS policy, or to use an alternate provider with very limited training and experience- is evidence of a reduction in Medicare beneficiary's access to quality and available healthcare services nationwide. I urge you to look at the bigger picture here, all areas of the nation's healthcare system will be negatively impacted, but none more than the already stressed urban healthcare delivery systems where we see the greatest concentration of the critically ill patient who is also more likely to be covered under the Medicare/Medicaid reimbursement system.

Submitter : Mrs. Lisa Peterson **Date:** 08/18/2006

Organization : Physicians Cardiovascular Diagnostic Center, L.L.P

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1787-Attach-1.DOC

1787

PHYSICIANS CARDIOVASCULAR DIAGNOSTIC CENTER, L.L.P.
2955 HARRISON STREET, SUITE 300
BEAUMONT, TEXAS 77702

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 Physicians Cardiovascular Diagnostic Center, L.L.P. (PCDC) and our six 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.

PCDC is a JCAHO accredited 7-bed outpatient cardiovascular catheterization facility utilized by six cardiologists, who perform catheterization procedures for 750-800 patients yearly. This one procedure room IDTF is located in Beaumont, Texas.

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,

Lisa Peterson, Administrator

Submitter : Douglas Fesler **Date:** 08/18/2006

Organization : American Society for Bone and Mineral Research

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment for comments to CMS-1512-PN: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

CMS-1512-PN-1788-Attach-1.PDF

1788

ASBMR
The American Society for Bone and Mineral Research

August 18, 2006

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

RE: CMS-1512-PN: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Comments on CPT codes 76075 (Dual energy X-ray Absorptiometry, DXA) and 76077 (Vertebral Fracture Assessment, VFA)

Dear Dr. McClellan:

The American Society for Bone and Mineral Research (ASBMR) is the premier professional, scientific and medical society for the promotion of bone and mineral research and the translation of that research into clinical practice. The ASBMR has a membership of nearly 4,000 physicians, basic research scientists and clinical investigators.

The ASBMR has learned that the Centers for Medicare & Medicaid Services (CMS) has proposed changes in the physician fee schedule for dual energy X-ray absorptiometry (DXA) and vertebral fracture assessment (VFA) reimbursement from approximately $140 to $40 and $40 to $25, respectively, based on decreases in work and practice expense relative value unit (RVU). ASBMR is concerned that these reductions will force physicians to discontinue offering these vital services and result in severe limitation of patient access to quality bone densitometry and vertebral fracture assessment. While ASBMR appreciates the effort of the CMS to establish equitable reimbursement policies for such diagnostic procedures as DXA and VFA, we would like to express support for the letter submitted to you by the International Society for Clinical Densitometry (ISCD) detailing the flaws in the data used by CMS to reach its conclusions. Furthermore, we request no changes be made to the current RVU for DXA and VFA and suggest that special resource considerations are necessary for these procedures to assure the widespread availability of high-quality screening for osteoporosis in the United States.

The assumptions CMS used to recalculate the Medicare Physician Fee Schedule are not accurate:

1. Practice expense: CMS calculated the DXA equipment cost at less than half of what it should be, because it based it on older pencil beam

2025 M Street, NW · Suite 800 · Washington, DC 20036-3309, USA · Tel: (202) 367-1161 · Fax: (202) 367-2161
E-mail: ASBMR@smithbucklin.com · Internet: www.asbmr.org

technology that is now infrequently used. In addition, the utilization rate for this equipment was set at a falsely high rate that does not reflect the average use rate of equipment used to evaluate single disease states. The majority of DXA studies (60%) are done by nonradiologists at point of service. Rather than the 50% rate assigned, DXA and VFA equipment utilization rates should be estimated at 21% based on a multi-specialty survey. Additionally, many densitometry costs such as necessary service contracts/software upgrades and office upgrades to allow electronic image transmission were omitted.

2. Physician work: 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. Furthermore, the implementation in 2007 of the new World Health Organization (WHO) paradigm of absolute risk, based on clinical risk factors and Bone Mineral Density (BMD), will require significantly greater practice time to obtain information on risk factors from the individual patient in order to calculate absolute risk.

Several recent forward-looking federal directives such as the Bone Mass Measurement Act, U.S. Preventive Services Task Force recommendations, the *U.S. Surgeon General's Report on Osteoporosis and Bone Health*, as well as your recent "Welcome to Medicare" letter, all recognize that despite the significant adverse health consequences of osteoporosis with direct costs of $17 billion yearly, osteoporosis is under-diagnosed and under-treated. These federal directives have appropriately highlighted 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. Osteoporosis is a major health care issue in this country with 44 million Americans with or at risk of developing the disease. 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. Though CMS data indicates testing is increasing, it still remains vastly under-utilized in this country. As such, special resource considerations are necessary for both DXA and VFA to assure widespread availability of high-quality screening in the United States.

If the new RVUs are enacted, the federal initiatives that CMS has championed to increase the diagnosis and treatment of osteoporosis will be severely undermined. Reducing DXA reimbursement will restrict availability of high quality bone mass measurement and force primary care physicians and specialists who are current providers of bone mass measurement to discontinue testing and will limit future purchases by other health care providers.

The ASBMR urges you to reconsider and withdraw these substantial cuts in the proposed rule that reduces Medicare reimbursement for these important technologies used to screen and identify individuals 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.

Respectfully,

Elizabeth Shane

Elizabeth Shane, M.D.
ASBMR President

Ann L. Elderkin, P.A.
ASBMR Executive Director

cc: Neil Binkley, M.D., CCD, *ISCD President*

Submitter : Dr. Gary Smith **Date:** 08/18/2006

Organization : Midland Family Physicians

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1512-PN-1789-Attach-1.DOC

CMS-1512-PN-1789-Attach-2.DOC

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

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

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

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

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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

CMS-1512-PN-1790-Attach-1.DOC

Attachment
1790

August 17, 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 an Proposed Changes to the Practice Expense Methodology.

Dear Dr. McClellan

As a physical therapist in private practice in Washington state for 39 years, I am writing to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises methodology for calculating practice expense RVUs under the Medicare Physician Fee Schedule. I am writing to urge CMS to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. It would seem much more appropriate to transition in the changes in the work related value units over a four year period in order to not jeopardize patient's continued access to healthcare services. Please note that under the current law the sustainable growth (SGR) formula is projecting a 4.6% cut in payments in 2007. The net result would be to pile cuts on top of cuts in reimbursement. These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. Access will be severely jeopardized for the elderly and disabled if the current law is not changed. The value of services provided by Medicare providers should be appropriate considering the amount of face-to-face consultation and treatment time physical therapists spend with patients.
I encourage repealing of the current law in order that other small businesses like mine will be able to continue to deliver healthcare to Medicare patients.

Thank you for your consideration of these comments.

Sincerely,

Harold Von Bergen, P.T.
Owner

CMS-1512-PN-1791 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

TO: Mark B. McClellan, MD, PhD
Administrator
Center for Medicare and Medicaid Services

I am writing to comment on the the June 29 proposed notice that proposes revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule.

I am a Physical Therapist and have been licensed as such for 38 years. I have been a Therapist in the US Army, worked in hospital departments and private offices and I have also worked as a therapist out side of the United States. I am currently CEO for several rehab. centers in Texas.

The proposal includes increasing payment for E/M services so physicians can manage illnesses more effectively; however, this is done at the expense of rehabilitation. Physical Therapists, OT s and Speech Pathologists cannot bill under E/M services, so the labor intensive services we provide end up loosing possibly up to 10% of our reimbursement. This loss of revenue seriously jeopardizes the integrity of care. I assume that the goal of the Medicare payment system is to preserve patient access to essential services and achieve greater quality of care because this gives better outcomes and in the long run will save money.

Those of us providing these essential rehabilitation services are experiencing marked increases in financial pressures by insurances as well as the pressures from increased energy prices, so decreasing our revenue per service would create a real crisis in this part of the industry.

Following is an illustration of how our expenses are increasing, although usage is remaining about the same.

Insurance costs have doubled over the past 3 years:
6/1/03 to 6/30/04 $58,072.50
6/1/04 to 6/30/05 $84, 715.41
6/1/05 to 6/30/06 $117,270.92

Utilities expenses:
6/1/03 to 6/30/04 $17,569.56
6/1/04 to 6/30/05 $22,334.27
6/1/05 to 6/30/06 $28,893.96

Transportation expenses:

6/1/03 to 6/30/04 $18,443.96
6/1/04 to 6/30/05 $30,733.28
6/1/05 to 6/30/06 $57,141.57

I respectfully urge CMS to ensure that Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. Cutting our reimbursement when we are experiencing such an increase in expenses would seriously jeopardize access to rehab care by the ones who often need it most.

Thank you very much for your consideration of my comments.

Sincerely,

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

Organization : GE Healthcare

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1792-Attach-1.DOC

1792

GE Healthcare

3000 N Grandview Blvd
Waukesha, WI 53188

August 18, 2006

The Honorable Mark McClellan, MD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
ROOM 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

ATTN: FILE CODE CMS-1512-PN

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

Dear Dr. McClellan:

GE Healthcare (GEHC) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding changes to the Medicare physician fee schedule (*Federal Register*, Vol. 71, No. 125, June 29, 2006). Our comments presented herein focus on the proposed adjustments to the relative values assigned to bone densitometry studies. GEHC also supports the comments of the National Electrical Manufacturers Association (NEMA), of which it is a member. We refer you to the NEMA comment letter for information regarding our additional comments.

Recently, there have been a number of regulatory and legislative initiatives that have the potential to greatly impact reimbursement for diagnostic imaging. These policies, when considered both individually and collectively, introduce varied and potentially harmful incentives for adoption of important advances in imaging. We urge CMS to consider the breadth and cumulative effect of these changes on reimbursement levels for diagnostic imaging, and to provide mechanisms that provide for equitable payment levels, enable stability in payment rates, and yield transparency in payment determinations.

Moreover, we are concerned about the effect that proposed severe payment reductions will have on availability of and access to quality diagnostic imaging services for Medicare beneficiaries. Herein, we address a particular concern with respect to the proposed work and practice expense values for bone densitometry studies (CPT 76075 *Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial*

skeleton (eg, hips, pelvis, spine) and request that CMS revise upward the relative values for this procedure.

GE Healthcare is a $15 billion unit of General Electric Company that is headquartered in the United Kingdom with expertise in medical imaging and information technologies, medical diagnostics, patient monitoring, life support systems, disease research, drug discovery and biopharmaceuticals manufacturing technologies. Worldwide, GE Healthcare employs more than 43,000 people committed to serving healthcare professionals and their patients in more than 100 countries. Lunar, a division of GEHC, is a leading manufacturer of bone densitometry equipment.

THE ROLE OF BONE DENSITY STUDIES IN CLINICAL CARE

According to the International Osteoporosis Foundation, one in three women and one in five men over the age of 50 years will suffer from an osteoporotic fracture. A woman's risk of hip fracture is equal to her combined risk of breast, uterine and ovarian cancer. The annual direct medical costs for the treatment of osteoporotic fractures totaled more than $17.5B in 2002 (period adjusted from 1995 total of $13.8M). Given these trends, it is not surprising that the World Health Organization has identified osteoporosis as a priority health issue, as did the Surgeon General in October 2005.

Early diagnosis and therapy are widely accepted as important measures to reduce or prevent fractures from occurring. The U.S. Congress recognized the importance of providing these preventive services and established the osteoporosis screening benefit that is available to Medicare beneficiaries today. Federal initiatives continue to focus on reducing the costs associated with osteoporosis through prevention and early treatment.

Nevertheless, restricted access to diagnosis and therapy before first fracture continues to be a challenge. We believe that the CMS proposed reductions in the relative values for bone densitometry procedures, an important diagnostic tool for physicians, will further restrict access to these medical services.

GEHC COMMENTS

The CMS proposal to revise the Medicare Physician Fee Schedule (MPFS) work relative value units and practice expense methodology will have major consequences for payment of bone densitometry procedures, also referred to as DXA procedures. Specifically, the changes proposed will result in a 71% decrease in reimbursement for central DXA (CPT code 76075) when fully implemented over the next four years. Based on the current CMS proposal, in 2010, the global reimbursement for central DXA procedures will decrease from the current national average of $139.46 to $39.79.

The CMS 5-year review included a targeted evaluation of the work value associated with DXA procedures. Generally, CMS relies on the Relative Value Update Committee (RUC), which makes recommendations to CMS based on standardized surveys conducted by professional societies for new or existing CPT procedures. In this case, the American College of Radiology (ACR) submitted survey data for these procedures to the RUC supporting maintaining the physician work RVU for DXA at the

current level, an RVU of 0.3. However, the RUC recommended reducing the work RVU to 0.2, asserting that the recommended reduction for the DXA work RVU was "because the workgroup believed that the actual work is less intense and more mechanical than the specialty society's description of the work" (*Federal Register*, Vol. 71, No. 125, June 29, 2006, page 98). CMS agreed with the RUC recommendation and proposes to reduce the work component by one-third, effective in 2007.

We strongly disagree with the RUC's recommendation to reduce the work component associated with these procedures. There are several diseases and therapeutic regimens associated with osteoporosis. Interpretation of DXA scans involves review of complex data and information, which is critical to accurate diagnosis and determination of appropriate therapy. This requires a high level of skill and physicians' time, as reflected in the ACR survey data. As a result, **we urge CMS to reconsider the recommendation of the RUC and to re-instate the work value for these procedures at .3, rather than the proposed level of .2.**

CMS has also proposed a new methodology to calculate the practice expense (PE) RVU. Based on this methodology, CMS proposes to reduce the DXA PE RVU by 76% over the next four years from a value of 3.10 to 0.61. Practice expense considers direct and indirect costs such as equipment purchase and maintenance cost, utilization time, office rent, etc.

We question the accuracy of the proposed practice expense values and request that CMS reconsider these estimates. The calculation used to determine the practice expense for DXA procedures is based on use of pencil beam technology whereas the vast majority of densitometers sold in the U.S. are fan beam technology. There are significant differences in the average selling price between these two technologies. Specifically, fan beam technology prices are approximately two times greater than that for pencil beam technology. Over the last few years, nearly 75% of densitometers sold by GEHC were fan beam technology. **We urge CMS to revise its estimate of practice expense for DXA procedures in order to more accurately reflect the type and cost of equipment associated with this service.**

We believe that these revisions to the work and practice expense values for DXA procedures is necessary in order to ensure continued availability of this important advance. Early diagnosis and treatment of osteoporosis, made possible with the aid of DXA, is an important measure towards prevention of fracture, its associated medical complications, and related costs of treatment.

*****

Thank you for providing the opportunity to comment on these important issues. Should you have any questions or wish to discuss our comments further, please contact me at (262) 548-2088.

Sincerely,

Michael Becker, J.H.P.

Michael S. Becker
General Manager, Reimbursement

CMS-1512-PN-1793 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Mrs. Jennifer Rocco **Date & Time:** 08/18/2006

Organization : Cambridge Physical Therapy Center

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

My name is Jennifer Rocco, Ohio PT License#: PT-7146, and Medicare provider#: 9304841. I am a Physical Therapist in private practice with 11 years experience overall and 8 years owning my own private practice. I wish to comment on the June 29 proposed notice that sets forth proposed revisions to work RVU's and revises the methodology for calculating practice expense RVU's under the Medicare physician fee schedule. I am urging CMS to ensure that severe Medicare payment cuts for physical therapists do not occur in 2007. We as physical therapists have a limited CPT code set we are able to use, and it is not limited to PT's, therefore it is and can be abused by many other non-PT health care professionals. The expense of running my practice increases each year, yet these proposed cuts would decrease my reimbursement and therefore undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment for these services are cut so severly, access to care for millions of the elderly and disabled will be jeopardized. Included in my concern is that PT's cannot bill for E/M services, therefore the increase in E/M reimbursement will not effect us, yet we spend a considerable amount of time in face to face evaluation and treatment with patients, and yet our services are being reduced in value. If the proposed cuts for physical therapists occur in 2007, it will be a devastating year not only for physical therapists, but for the millions of Medicare beneficiaries who will lose their access to care and quality of care. The Medicaid system has seen an increase in the percentage of health care professionals not accepting new Medicaid patients because of their extremely low reimbursement and administrative hassles, and I fear that should these proposed cuts occur, the same will happen to the Medicare system which will only hurt Medicare beneficiaries. Thank you for your consideration of my comments. Sincerely, Jennifer L. Rocco, PT

CMS-1512-PN-1794 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Dr. Beryl Lougachi **Date & Time:** 08/18/2006

Organization : Dr. Beryl Lougachi

Category : Other Practitioner

Issue Areas/Comments

Practice Expense

Practice Expense

As a clinical psychologist for the past 16 years, I am amazed at the lack of understanding Medicare has for the fact that the most common psychiatric diagnosis among people 65 years old and up is depression. Medicating them (when many of them are already on a plethera of medications) does not assist them in dealing with the losses that most of them face. Does CMS exist to provide necessary services, or just to make life more difficult for the people they are supposed to be providing services for? Decreasing reimbursement for real mental health providers (but NOT psychiatrists, who typically only dispense medication to this population, due to their low reimbursement) displays an extreme prejudice towards services that are necessary and needed.

Submitter : Ms. Dori Rodriguez **Date:** 08/18/2006

Organization : Nebraska Heart Institute

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : Dr. Henry Bone **Date:** 08/18/2006

Organization : Michigan Consortium for Osteoporosis

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached letter.

CMS-1512-PN-1796-Attach-1.PDF

MICHIGAN CONSORTIUM FOR OSTEOPOROSIS

1796

Outreach Office: 22201 Moross Road, #260
Detroit, Michigan 48236
Toll Free: 1-866-MCO-0315

August 15, 2006

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

RE: CMS-1512-PN: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Comments on CPT codes 76075 (Dual energy X-ray Absorptiometry, DXA) and 76077 (Vertebral Fracture Assessment, VFA)

Dear Dr. McClellan:

I am writing on behalf of the Michigan Consortium for Osteoporosis. The MCO is an organization of health care professionals concerned with osteoporosis and particularly with the assurance of high-quality diagnostic testing for this important health problem. We provide consultation to the Michigan Department of Community Health, participate in statewide public health programs and provide professional education in this area.

CMS has recently proposed a dramatic reduction in the reimbursement for bone mineral density measurements by dual-energy X-ray densitometry (DXA) and vertebral fracture assessment (VFA) provided in physician's offices. The proposal would greatly impair the ability of physicians to provide an important service:

Osteoporosis testing is a very important public health concern:

- Osteoporosis results in debilitating, costly and preventable fractures, which not only result in suffering, dependency and deaths due to complications, but also enormous costs of care, far exceeding the costs of osteoporosis treatment, which is effective in reducing fracture risk.
- Demographics dictate the coming "epidemic" of osteoporosis.
- The importance of osteoporosis was recognized by the recent issuance of a Surgeon General's Report.
- Bone density testing is essential in the detection and treatment of osteoporosis in post-menopausal women and other susceptible individuals.
- The importance of bone density testing has been recognized in the recent Medicare quality assessment initiatives, which specifically emphasize that obtaining these tests is an important mark of good health maintenance.

The process by which the reimbursement formula was recalculated was seriously flawed:

- The estimated cost of the testing equipment was underestimated by more than 50% ($41,000 vs. an average of 86,000).

- Operating costs were also seriously underestimated.
- The assumed number of tests that would be performed per machine per year was unrealistically high, roughly three times the best estimates.
- The amount of physician time per test was seriously underestimated. A panel that apparently did not include physicians with expertise in the area arbitrarily reduced the estimated physician effort.
- Thus the cost of providing these tests was grievously underestimated.

The result will be disadvantageous to patients:

- The proposed reduction of reimbursement will make it economically impossible for physicians to provide this service to their patients.
- The result will be increased suffering, increased dependency and increased ultimate costs to Medicare and society
- The quality improvement effort initiated by CMS in this area will be defeated.

The International Society for Clinical Densitometry has addressed the above concerns in detail in the Society's comments. We join with the ISCD in pointing out that the costs of providing this essential service were seriously underestimated. We too would welcome the opportunity to communicate further with the Center for Medicare and Medicaid Services regarding the issues raised in this letter.

Very truly yours,

Henry G. Bone, M.D.
President, Michigan Consortium for Osteoporosis

Gary Edelson, MD, Secretary
Michael Kleerekoper, MD, Director
Melody MacMartin, DO, Director
Dorothy Nelson, PhD, Director

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

Organization : Mental Health

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

i.e.see Attachment NASW on 7% proposed fee reduction. I am fearful that mental helath therpay cannot continue to elderly outreach and office if fee reductions go into effect. Gasoline has been prohibitive in price to travel to nearby County to see mentally ill elderly and LMSW s like me provide majority of mental health therpay to elderly and people i USA. We should also be allowed back to Nursing Homes if these folks enter temporarily for broken hips, etc.!!! Please write me thans Patricia Mazzello

Submitter : Mr. Jason Scull **Date:** 08/18/2006

Organization : Infectious Diseases Society of America

Category : Health Care Professional or Association

Issue Areas/Comments

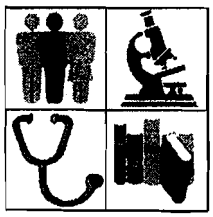
GENERAL

GENERAL

"See Attachment"

CMS-1512-PN-1798-Attach-1.PDF

Attach #
1798



IDSA
Infectious Diseases Society of America

August 21, 2006

Mark McClellan, MD
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 21244-1850

Re: Comments on Proposed Notice [Docket No. CMS-1512-PN]: Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan:

I am writing on behalf of the Infectious Diseases Society of America (IDSA) to offer comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Notice regarding changes to the work relative values of services included in the 2007 Physician Fee Schedule.

IDSA appreciates the time CMS staff has spent in developing the Proposed Notice; including proposing finalization of the Evaluation and Management (E/M) service codes work Relative Value Unit (wRVU) recommendations submitted by the American Medical Association's (AMA) Relative Value Update Committee (RUC) earlier this year. IDSA was one of several medical specialty societies that played a leading role in the effort to appropriately value these E/M service codes through the RUC as part of CMS's Five-Year Review of Current Procedural Terminology (CPT) codes.

IDSA also appreciates the challenge of making the proposed changes to the physician wRVUs and the practice expense methodology budget neutral and recognizes CMS was faced with choosing either a 5% conversion factor adjustment or a 10% wRVU adjustment. Notwithstanding our appreciation, the 2007 budget neutrality adjustment will undermine many of the gains cognitive specialists, including infectious diseases (ID), made during the Five-Year Review of E/M service codes.

IDSA will comment on the following issues raised by the Proposed Notice:

- CMS should finalize the E/M service codes wRVU recommendations submitted by the RUC and included in the Proposed Notice.

- The 10 and 90-day global surgical periods should be replaced by a system that measures the actual amount of post-service work included in these global surgical services.

- Budget neutrality should be maintained through a conversion factor adjustment rather than a wRVU adjustment.

- The new drug administration codes should not be included in the 2007 proposed wRVU budget neutrality adjustment.

BACKGROUND

IDSA represents nearly 8,000 infectious diseases physicians and scientists devoted to patient care, education, research, and public health. The Society's members focus on the epidemiology, diagnosis, investigation, and treatment of infectious diseases as well as working to prevent them in the U.S. and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, surgical infections, those with cancer or transplants who have life-threatening infections caused by unusual microorganisms and new and emerging infections, such as severe acute respiratory syndrome (SARS) and influenza.

DISCUSSION OF COMMENTS—EVALUATION AND MANAGEMENT SERVICES

The effort to appropriately value physician work associated with 35 E/M service codes, which began with a December 2004 letter to CMS, was undertaken by a coalition of 27 medical specialty societies working through the RUC during Medicare's Five-Year Review of CPT codes. The coalition letter argued that the intensity, complexity, and duration of E/M services had increased over the past 10 years with no corresponding increase in work relative value.

After the coalition completed a survey process and gathered evidence supporting the position that physician work had increased, wRVU recommendations for E/M service codes were submitted to the RUC in September 2005. The medical specialties, which perform the majority of E/M services and depend on them for their economic survival, spent several days presenting evidence to the RUC and defending the data, which demonstrated that physician work for these services had increased since they were last reviewed in 1995.

The E/M service code wRVU recommendations submitted by the RUC will help to guarantee patient access to cognitive specialties, such as infectious diseases, that have long experienced reduced payments compared to their surgical colleagues. IDSA appreciates CMS's validation of this effort and we strongly urge CMS to finalize these E/M service code wRVU recommendations included in the Proposed Notice.

OTHER ISSUES—POST-OPERATIVE VISITS INCLUDED IN THE GLOBAL SURGICAL PERIODS

IDSA appreciates CMS's request for comments on whether the number and level of visits within global periods reflect the actual post-operative work done, especially with regards to

E/M services. IDSA contends that physicians of all specialties should adhere to similar documentation requirements and be paid for their work in an equivalent manner. If surgeons are not providing the number of E/M visits assumed in the valuation of 10 and 90-day global periods, then the current work values for these global codes are likely too high.

CMS should further study this issue to ensure that physicians are paid appropriately for the work that they provide to Medicare beneficiaries. As such, IDSA joins the American College of Physicians in urging CMS to conduct a study on the impact of eliminating the 10 and 90-day global periods. Such a study could potentially address several issues, including the extent to which the number and level of visits within global surgical periods reflect the actual post-operative work done, budgetary implications of eliminating the global surgical periods, and possible unintended consequences.

OTHER ISSUES—BUDGET NEUTRALITY

The recommended wRVU increases included in the Proposed Notice requires CMS to make a budget neutrality adjustment to offset the spending increases that would otherwise occur. Since the Five-Year Review focused on physician work only, CMS proposed a negative 10 percent wRVU adjustment. IDSA disagrees with CMS's decision to impose a wRVU adjustment and believes that a negative 5 percent budget neutrality adjustment to the 2007 conversion is preferable for several reasons.

Adjusting the wRVUs has the potential to inappropriately affect relativity because such an adjustment does not consistently impact all services in the physician fee schedule. Services that involve more work will be disproportionately, negatively impacted relative to other services that involve less work. Unlike a wRVU adjustment, an adjustment to the 2007 conversion factor would maintain relativity and consistently impact all services in the physician fee schedule.

Second, if the wRVUs are adjusted as proposed, it will obfuscate the recommended changes and disproportionately impact those services with low practice expense, such as the E/M service codes. Inpatient E/M service codes, such as those used by ID physicians, will be negatively impacted the most. Adjusting the conversion factor will leave the recommended changes in the E/M service code wRVUs unscathed.

Many private payers use the RVUs included in Medicare's physician fee schedule to determine their payment rates. Unlike an adjustment to the conversion factor, a wRVU adjustment would disproportionately impact payers that peg their payment rates to Medicare's physician fee schedule. While an adjustment to the conversion factor would still impact those payers that pay a percentage of Medicare, IDSA believes a conversion factor adjustment would have less of a ripple affect than a wRVU adjustment.

Finally, we believe an adjustment to the conversion factor is preferable because it recognizes that budget neutrality is a fiscal issue, not an issue of relativity. Budget neutrality is statutorily

mandated for fiscal (or monetary) reasons. Thus, the conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality.

NEW DRUG ADMINSTRATION CODES—BUDGET NEUTRALITY

IDSA also believes strongly that the newly created drug administration service codes should be excluded from the 2007 proposed wRVU adjustment because these codes are new for 2006 and, as such, were not included in Medicare's Five-Year Review of CPT codes. Additionally, when these codes were initially valued by the RUC in 2004, they were held outside of budget neutrality due to the simultaneous decrease in drug reimbursement mandated by the Medicare Modernization Act of 2003. It seems disingenuous to include these codes in a budget neutrality adjustment the year after they went into effect.

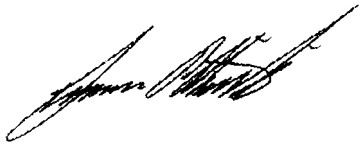
Additionally, lingering questions remain regarding the adequacy of Medicare's new drug reimbursement system, based on the Average Sales Price methodology. A budget neutrality adjustment that includes the new drug administration codes could limit patients' access to critically needed, life-saving drugs and biologicals, such as antibiotics and Intravenous Immune Globulin, administered in the physician office.

CONCLUSION

IDSA appreciates this opportunity to comment on Medicare's 2007 Proposed Notice concerning the Five-Year Review of work relative value units under the Physician Fee Schedule. We believe that CMS should include the proposed E/M service code wRVU changes in the 2007 Physician Fee Schedule Final Rule published later this year. Furthermore, we share CMS's concerns regarding the 10 and 90-day global surgical periods and would favor, as an alternative, a proposal by CMS to adopt 0-day global surgical periods. Finally, IDSA favors a conversion factor adjustment to maintain relativity in the physician fee schedule, to keep the E/M wRVU increases intact, and to minimize the impact on private payers.

If you have any questions concerning this matter, please contact Robert J. Guidos, JD, IDSA's Director of Policy and Government Relations, at 703/299-0200. We look forward to working with CMS as it finalizes these regulations.

Sincerely,



Lawrence P. Martinelli, MD, FACP, FIDSA
Chair, IDSA's Clinical Affairs Committee

Submitter : Dr. James W. Middleton **Date:** 08/18/2006

Organization : Family Medical Center of Hart County

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1799-Attach-1.DOC

Attach FF
1799

August 18, 2006

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

RE: CMS-1512-PN

Dear Sirs:

Osteoporosis is a disease process that has dehabilitated the members of my family and the people of our community for generations. In the past we accepted it as a natural process of aging. We now know it is a preventable disease. For seven years our clinic (the primary health care provider in this rural area) has worked through out this area to prevent osteoporosis. We know can stop most of the unnecessary broke bones in our senior citizens. Part of this prevention program is the use of the Dexa Scans in our clinic. At the new proposed Medicare reimbursement rate we cannot afford to operate our dexa machine. We certainly will not be able to update it or make any repairs on it if it malfunctions. The effect of the proposed reduction for Dexa Scans reimbursement by Medicare will shut down one of the most effective programs our clinic provides for the health care of our senior citizens. This is outrageous to say nothing of being unethical. Medicare cannot lower the already low reimbursement rate for Dexa Scans.

I will be asking my representatives for their help in stopping any Medicare reductions in reimbursement for Dexa Scans (CMS-1512-PN; RIN 0938-A012; CPT 76075).

Sincerely,

James W. Middleton, Jr., M.D., PhD.

Submitter : Mrs. Jennifer Briggs **Date:** 08/18/2006

Organization : Family Medical Center of Hart County

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1800-Attach-1.DOC

Attach #
1800

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

Jennifer D. Briggs, ARNP
117 W. South Street
Munfordville, KY 42765

August 18, 2006

Dear CMS,

I am a nurse practitioner in Munfordville, Kentucky. My practice is located in one of two family practice clinics in the county. I am writing you to discuss CMS 1512-PN and its effects on preventative health. Currently, our office can offer bone density testing through DEXA imaging. We service a large amount of people of which has risk factors for osteoporosis: the elderly, post-menopausal, etc. Each year, society spends 20 billion dollars as result of hip fractures (Medline, 2006). The National Osteoporosis Foundation (2006) defines the prevalence as one in two women and one in four men will develop osteoporosis without treatment. As you are aware, osteoporosis can cause height loss, pulmonary complications, fractures of the vertebral bones with chronic back pain, and stated previously hip fractures. While our clinic does all we can to help with the underserved, indigent medication programs, health fairs, etc., we highly depend on the reimbursement of the services we provide. Cutting the DEXA reimbursement would probably discontinue our osteoporosis program. This would then cause a decline in osteoporosis treatment, as we would not be able to monitor efficacy of drug therapy or find those patients that have new onset bone loss. Osteoporosis is not a normal part of aging. It is a preventable disease and should be treated as soon as part of our primary prevention. At the rate of less than $40.00, we would not be able to pay the staff to run the machine nor the maintenance of the machine. Please reconsider the proposed global reimbursement reduction of this much-needed service.

Sincerely,

Jennifer D. Briggs, ARNP

CMS-1512-PN-1801 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : Mr. B Spiares **Date & Time:** 08/18/2006

Organization : Diagnostic Clinic

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

To the honorable members of CMS, I am a technician working in association with doctors of Oncology/Hematology/Rheumatology whom order intravenous treatment for their patients. Where the implementation of the methodology for RVUs and ASP+6 is understandable for deficit reduction, the cost to those of us who work in the medical field is too great. I speak especially of support personnel. I have worked in this field for 25 years and have not received any wage increase in over two years due in part to the reimbursement cuts to doctors and clinics. I find myself at a point where working in this field is no longer practical. The proposed methodologies may drive experienced, seasoned medical workers out of the industry.

Submitter : **Matthew Twetten** **Date: 08/18/2006**

Organization : **North American Spine Society**

Category : **Physician**

Issue Areas/Comments

**Discussion of Comments-
Gynecology, Urology, Pain
Medicine**

Discussion of Comments- Gynecology, Urology, Pain Medicine

Please see attached word and PDF files for your records. Thank you.

CMS-1512-PN-1802-Attach-1.DOC

CMS-1512-PN-1802-Attach-2.PDF

Attach #
1802

August 18, 2006

Mark McClellan, MD, PhD
Administrator, Centers of Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1512-PN
PO Box 8014
Baltimore, MD 21244-8014
http://www.cms.hhs.gov/erulemaking

Dear Doctor McClellan:

The North American Spine Society (NASS) and the American Association of Orthopaedic Surgeons (AAOS) wish to thank the Centers of Medicare and Medicaid Services (CMS) for their efforts in evaluating and updating the physician fee schedule through the five year review process. Our societies wish to present comments regarding the section of the rule regarding the seven spine surgery codes that were part of the five year review. We appreciate the opportunity to further clarify our methodology and the data derived and in doing so, hope to show that the RUC proposed values for these two codes are in fact, the correct values. Please find our comments below.

Comments on National Proposed Rulemaking, Register Number CMS-1512-PN
Discussion of Comments-Gynecology, Urology, Pain Medicine and Neurosurgery

We are happy that CMS choose to accept the RUC recommended values for codes 22520, 22554, 22840, 63047 and 63075. However, we believe that CMS misinterpreted the data we presented in support of our recommended values for codes 22612 and 63048 due to our unique survey methodology.

We would like to emphasize to CMS that the same methodology and the same summary of recommendation forms used for 22612 and 63048 were used for the five spine surgical codes for which CMS accepted the RUC recommended values. We believe that by accepting five of the RUC recommendation that CMS has demonstrated confidence in the methodology of the survey and the presentation of the results, and that given this confidence it is appropriate to accept the recommendations of the remaining two recommendations, 22612 and 63048 rather than the values proposed in the rule. Furthermore, we believe it is appropriate for CMS to apply a consistent approach to this RUC approved methodology. We believe it is inconsistent to accept the RUC recommended values for five codes which were to either remain unchanged or reduced and reject the same methodology for the two values which were recommended for slight increases. We request that CMS reconsider their ruling and accept the RUC recommended values for 22612 and 63048.

22612

NASS recommended an increase in the value for 22612 from the current (and proposed) value of 20.97 to a new value of 22.58. We utilized a building block methodology that accounted for increases in the complexity and intensity of all categories surveyed for this code during the past 5 years. Our original recommendation of 22.58 fell between the median and 25th percentile. The RUC workgroup reduced this to 22.00 (the 25th percentile), a value which was subsequently accepted by the full RUC.

We had a large response rate of over 200 total responses and a tight cluster of those responses about the median value (25th percentile- 22.00, median-23.00, 75th percentile-25.00). This is evidence of the statistical evidence of our survey results. For comparative purposes, the previous survey done by the RUC in 1995 had only 59 respondents.

As part of the rationale for rejecting the RUC recommended value of 22.00, CMS states that the workgroup's recommendation was based largely on a typographical error that listed the primary reference code, 22595, as having a work value of 23.36 instead of the current value of 19.36. We utilized a unique RUC approved methodology that assessed the changes in work and complexity that occurred for each code during the past five years. The RUC research committee also requested that two codes not included in the five year review also be surveyed for comparison. We selected 22595 (current value 19.36) for survey and obtained a new survey median value of 23.36 for this code based upon 182 responses. Thus our respondents believed that the median values for both 22612 and 22595 were similar (23.00 vs 23.36) and that both codes had increased in value during the past 5 years (22612 from 20.97 to 23.00) and (22595 from19.36 to 23.36). While 22595 was not part of this Five year review and is not under consideration, we believe our survey provides evidence that this code also is undervalued (all eleven intensity and complexity measures had increased during the past five years-range 3.54-4.55) and plan to address this in the next 5 year review.

If the incorrect value for 22595 had been seen by respondents to the survey, it is possible that the recommendation for 22612 had been influenced. However, respondents did not see this value listed, and derived their recommendations, not from a typographical error, but rather by following the RUC research committee approved instructions to compare the work and intensity involved in performing the procedure in 2005 to the work and intensity involved in performing the procedure in 2000. It is for this reason that we firmly believe the typographical error referred to by CMS had no influence on the survey results or on the materials presented to the RUC at the August and September Five Year Review meetings.

The increase recommended for 22612 was further justified based upon increases for all intensity and complexity measures surveyed. Respondents were not asked to compare the intensity of one code against another, as is done in the traditional RUC survey, but to compare on a scale of (1 to 5) how complexity and intensity have changed in the past 5 years. A value 1 or 2 represented a decrease in intensity and complexity, a value of 3 signified no change, and a value of 4 or 5 represented an increase. Again survey respondents felt that the intensity and complexity for both codes had increased during the past 5 years with all values being above 3.5 and three measures (the amount and/or

complexity of information that must be reviewed and analyzed, the skill and judgment of physician, and the risk of malpractice suite with poor outcome) all being above 4.

Additional support for a value of 22.00 can be obtained by comparing the IWPUT of the proposed value with that of other recently reviewed spine codes. The IWPUT for 22612, at the RUC recommended value of 22.0 RVW, is 0.089. This compares favorably with IWPUT of code 63050, cervical laminoplasty, a spine code recently reviewed by the RUC in April 2004. 63050 has an IWPUT of .085, a RVW of 20.75 and a similar intraservice time of 150 minutes. 22612 has higher level in-hospital visits (1-99231 and 2-99232 vs 2-99231 and 1-99232)and also higher level post op visits (3-99213 vs 2-99213 and 1-99212).

63048

NASS recommended an increase in the value for 63048 from the current (and proposed) value of 3.26 to a new value of 3.6.

The rationale that yielded this recommendation was based on a crosswalk of IWPUT from the base code of 63047 to the add-on code of 63048. 63047 (laminectomy for stenosis) was also part of the five year review. NASS recommended a value of 14.08 for 63047 (less than the 25th percentile). The RUC approved this value and CMS has also proposed to accept this as the new value. Crosswalking the IWPUT for 63047 at this proposed value (IWPUT= 0.080) and multiplying by our median intraservice time of 45 minutes results in an RVW of 3.60. (45min x 0.080iwput = 3.60)

This value of 3.6 is very close to our 25th percentile survey value of 3.55 which the RUC accepted. We believe our survey results are more accurate than the current value, which is based upon Harvard data, due to the large response rate of 199 responses.

The rule stated, on page 87, that no information is given that compares the respondents' estimates of complexity and intensity between CPT code 63048 and the reference code because the summary of recommendation form did not list a reference code. However, this was done because our respondents compared the complexity and intensity currently involved in the work of 63048, not with a separate code, but with the complexity and intensity involved in the work of 63048 five years ago. Our survey respondents identified that all eleven intensity and complexity measures had increased in the past 5 years (range 3.31 - 4.34) with only a small decrease in intraservice time (51 to 45 minutes). Just as we did in our summary of recommendation forms for the other six codes, we outlined this process in the additional rationale section of the form and also clarified that a value of 3.55 was very near the 25th percentile value from our survey results.

Therefore, we believe that a value of 3.55 is correct, given the global increases in intensity and complexity, selecting the 25th percentile of a very large survey response, and the IWPUT correlation with the base code 63047.

We wish to thank you for your time and consideration of this additional evidence in reference to the two CPT codes, 22612 and 63048, that had proposed values that deviated

from the RUC recommended values. If you have further questions or wish to discuss these results further, we are available for additional discussion and review.

Sincerely,

Claire Tibiletti, MD
NASS RUC Advisor

Robert D. Blasier, MD
AAOS RUC Advisor

CC: Eric Muehlbauer
Tom Faciszewski, MD
Charles Mick, MD
Gregory Przybylski, MD
Bernard Pfeifer, MD
Daniel Sung
Matthew Twetten

Submitter : Dr. Deborah Bash **Date:** 08/18/2006

Organization : American Society of Plastic Surgeons

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1803-Attach-1.PDF

CMS-1512-PN-1803-Attach-2.PDF

CMS-1512-PN-1803-Attach-3.PDF

Attach FF
1803

AMERICAN SOCIETY OF PLASTIC SURGEONS

Executive Office
444 East Algonquin Road
Arlington Heights, IL 60005-4664
847-228-9900
Fax: 847-228-9131
www.plasticsurgery.org

August 18, 2006

Mark McClellan, MD, PhD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

SUBMITTED ELECTRONICALLY: http://www.cms.hhs.gov/eRulemaking

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

Dear Dr. McClellan:

The American Society of Plastic Surgeons (ASPS) is the largest association of plastic surgeons in the world, representing surgeons certified by the American Board of Plastic Surgery. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer. ASPS promotes the highest quality patient care, professional, and ethical standards and supports the education, research and public service activities of plastic surgeons.

ASPS offers the following comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule for "Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology" that was published in the June 29, 2006 *Federal Register*. As requested in the proposed rule, the relevant "issue identifier" that precedes the section we are commenting on is used as a sub-heading throughout this letter to assist the Agency in reviewing these comments.

Discussion of Comments - Dermatology and Plastic Surgery

ASPS is pleased that CMS has agreed with the RUC recommendations made for the plastic surgery codes that were reviewed in the third Five-Year Review of the RBRVS. Many ASPS members contributed to

the RUC process by completing physician work surveys last summer to help determine appropriate values for nearly 50 plastic surgery procedures. We also had several plastic surgeons in attendance at the RUC's Five-Year Review sessions held in 2005. These physicians helped provide clarification to the RUC members and CMS officials present that were assigned to review recommendations made by ASPS. Plastic surgeons also participated on RUC workgroups and facilitation committees that evaluated recommendations made by other specialties, including the workgroup that was given the arduous task of reviewing the Evaluation and Management Services codes. In making final value recommendations on certain plastic surgery codes, ASPS partnered with many other specialties that also perform these services, including the American Society of Maxillofacial Surgeons, the American College of Surgeons, the American Academy of Dermatology, the American Academy of Otolaryngology - Head and Neck Surgery, the American Society for Surgery of the Hand, the American Burn Association, and the American Podiatric Medical Association. The successful result of our combined efforts helps demonstrate the unique, collaborative nature of the RUC, which brings together multiple specialties to build consensus on, at times, highly contentious issues. It is gratifying to see that CMS approved the RUC's recommendations for these services.

For purposes of clarification only, I wish to point out that CPT code 19361 (*Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant*) that is listed on Table 3 on page 37189, was not withdrawn from the Five-Year Review by ASPS due to a low survey response rate. Instead, the RUC Workgroup reviewing the issue was uncomfortable assessing the value of the code, despite a valid survey, because the descriptor contained a "with or without" phrase. The Workgroup members suggested that ASPS might want to withdraw the code from the Five-Year Review and present a proposal to the CPT Editorial Panel to revise the descriptor at a later date. ASPS followed this recommendation, and the CPT Panel agreed to revise the code at our request at the February 2006 meeting. We anticipate the revised code descriptor will appear in CPT 2007.

Other Issues

Discussion of Post-Operative Visits Included in the Global Surgical Packages

In this proposed rule, CMS announces plans to apply the RUC-recommended new values for the Evaluation and Management (E/M) services to all surgical services with a 10 or 90-day global period. The Agency requests comments on this proposal. We strongly recommend that CMS go forward with this important step to ensure equity in the payment of physician services. The post-operative work (i.e., follow-up visits) included in 10 and 90-day global procedures can be significant and cannot be reported separately for payment. The long-standing policy is that this work is "built in" to the total RVUs for these services. Thus, it is highly appropriate for CMS to adjust the RVUs for these services to account for the revised values of the applicable E/M services.

Budget Neutrality

ASPS understands that CMS is required by law to ensure each year that increases or decreases in RVUs do not cause the amount of Medicare Part B expenditures for the year to differ by more than $20 million from what spending levels would have been in the absence of these changes. Since the early years of implementation of the RBRVS, CMS has made various adjustments to physician payment to preserve budget neutrality. In this proposal, CMS indicates a preference for 2007 for creating a "budget neutrality adjustor" that would reduce all work RVUs by approximately 10 percent. **ASPS strongly urges CMS to**

reconsider this proposal. As a long-standing participant in the RUC process, ASPS supports the RUC's consistent request that any budget neutrality adjustments related to improvements in the work relative values be applied to the conversion factor, rather than to the work relative values. Making the necessary adjustments to the conversion factor prevents possible detrimental effects on the relativity of services in the RBRVS. This is particularly crucial in a year that follows an intense effort to improve the physician work component of the RBRVS through the third Five-Year Review, and it would be counterproductive to make negative adjustments on the newly approved values. In addition, the RBRVS, including its physician work, practice expense, and practice liability components, has been adopted by many private health insurance carriers. However, these private carriers establish independent conversion factors based on their own budgetary concerns; they do not annually adopt the Medicare conversion factor. Therefore, any adjustments CMS makes to the Medicare conversion factor will not affect payments from other carriers. It is beneficial for all concerned that all services valued in the RBRVS retain the CMS and RUC-approved values.

Incidentally, ASPS co-signed with multiple specialty societies onto an August 10, 2006, letter requesting a meeting with you to further discuss this budget neutrality issue. We are hopeful that you will be able to schedule such a meeting prior to CMS releasing the final rule for the 2007 physician payment schedule.

Practice Expense

CMS is proposing a new practice expense methodology, which combines a "bottom up" and a "top down" approach. ASPS does not have specific comments on the methodology at this time. Our Board of Directors is currently considering a proposal to contribute to the multi-specialty practice expense survey that is being coordinated by the American Medical Association. Given the high price tag for such an endeavor, it would be extremely helpful while our Board ponders its commitment to this effort if CMS could provide reassurance that any such survey data would be used as soon as feasible by the Agency if it is collected by the specialties.

As always, we greatly appreciate your consideration of these comments. We will continue to carefully monitor future correspondence on these and other relevant health care issues.

Sincerely,

Deborah S. Bash, MD
Chair, ASPS Payment Policy Committee

Submitter : Mr. Frederic Simmons **Date:** 08/18/2006

Organization : Clearwater Cardiovascular and Interventional Consu

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attached

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.