CMS-1512-PN-1805 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Mr. Brad Kruer** **Date & Time:** **08/18/2006**

Organization : **Southern Indiana Rehab Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

My name is Brad Kruer, and I am a Physical Therapist in the State of Indiana. I am a Supervisor of a hospital-based outpatient therapy department and have been in practice for 8 years. Our department s caseload consists of about 50% Medicare recipients. The purpose of this letter is to comment on the June 29 proposed notice (CMS-1512-PN) that sets forth proposed revisions in the methodology for calculating the Medicare physician fee schedule.

The proposed changes to the work relative value units (RVUs) has the potential to dramatically impact the ability of Medicare recipients to access valuable health care services. While the RVUs for evaluation and management (E/M) codes are set to increase, physical therapists and other non- physician practitioners, who cannot bill these codes, will face a 4-10% cut in payment beginning January 1, 2007. These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access to quality care that is provided by physical therapists. Physical therapists, and other non-physician practitioners, spend a considerable amount of time in face-to-face consultation and treatment with patients, yet their services are being reduced in value.

It is my suggestion that CMS reconsider these reductions in the RVUs and take steps to preserve a patient s access to physical therapy and other non-physician healthcare services. I recommend this be accomplished by either setting RVUs that are of fair value to the services provided or by phasing the already proposed changes in over a 4-5 year period.

Thank you for your time and consideration.

Sincerely,

Brad Kruer, MPT
Physical Therapist

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

Organization : **Clearwater Cardiovascular and Interventional Cons**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1512-PN-1806-Attach-1.DOC

Attach # 1806

Clearwater Cardiovascular and Interventional Consultants

455 Pinellas Street, Suite 400

Clearwater, Florida 33756

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

Dear Dr. McClellan:

On behalf of Clearwater Cardiovascular and Interventional Consultants(CCIC) and our 19 individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

CCIC has been operating an outpatient cardiac catheterization laboratory for over 5 years. The lab is operated as a part of our practice and operates much more efficiently than the hospital based labs in the hospitals where we practice. The CCIC lab is used by 7 invasive cardiologists and performs approximately 1500 outpatient procedure per year.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact that the proposed methodology has 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 we believe were submitted by the Society for Cardiovascular Angiography and Interventions ("SCAI") through the American College of Cardiology. 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 to the RUC, 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 not 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 the 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 that do not reflect the cost profile of cardiac catheterization facilities. Instead, cardiac catheterization facilities 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 catheterizations 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 more accurate 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 to evaluate the impact of the PE RVU methodology on our practices.

Sincerely,

Frederic R. Simmons, Jr. CPA

Chief Executive Officer

CMS-1512-PN-1807 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

I am a physical therapist assistant and have been practicing for two years in Oklahoma. My first year of practicing I obtained a variety of experience providing home health, school system, acute care, inpatient rehab, and long term acute care services. The last year I have been in an outpatient rehab clinic. In that last year there have been significant changes made by Medicare.
I am writing to address the new policies being considered. I would like to take the opportunity to urge you to ensure that severe Medicare payment cuts for physical therapy do not occur in 2007. It is unreasonable to propose policies that pile cuts on top of cuts. These proposed cuts make it impossible to have a Medicare payment system that preserves patient access and achieves a greater quality of care. If payment for these services is cut so severly, access to care for millions of elderly and disabled people will be jeopardized. I feel there is a huge problem when we reach the point where patient care is dictated by insurance guidelines and reimbursement. However that is exactly where we are. No longer is a physical therapist entrusted to have the skill to evaluate, assess, and outline a treatment plan that provides optimum care. Instead therapist are having to consider if they will be adequately reimbursed for services provided and time spent with the patient,in order to make a profit.
Currently the elderly population is afraid to seek the care they need to improve their daily function. Since the Medicare cap was implemented there has been a significant decline in the number of elderly people seeking physical therapy services. As a result most outpatient clinics have already experienced a significant cut. Now we are faced with the possibility of more cuts. This has to stop. We must see to it that the elderly population is given the freedom to seek care and that it is of the highest quality.
In conclusion I urgue you to consider the negative impact these new policies will have on our profession and the quality of care the elderly are receiving. Thank you for your consideration.

CMS-1512-PN-1808 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Dr. Agnes Nall** **Date & Time:** **08/18/2006**

Organization : **Ear Nose and Throat Assoc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Hi,
I hope this finds you well. I am a practicing otolaryngologist from Bradenton, FL. I was made aware of your proposed cuts in reimbursement to the field of Anestheisology. Please reconsider this for the following reasons. Their cost to deliver excellent healthcare continues to increase, yet they have had significant cuts over many years. They are unalble to replace old equipment, critical monitoring devices, and deliver safe health care if the current cuts are passed. The proposed plan was not based on sound or true practice expense methodology. Please consider increasing their reimbursement to alllow our patients to be cared for safely. Thank you,
Sincerely,

Agnes V. Nall, MD

Submitter : **Dr. Keith Anderson** **Date: 08/18/2006**

Organization : **Sutherland Cardiology Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment - Response from 18 cardiologists

CMS-1512-PN-1809-Attach-1.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 : **Dr. Stanley Fineman** **Date: 08/18/2006**

Organization : **Joint Council of Allergy, Asthma and Immunology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1810-Attach-1.DOC

A-Hach #
1810

Joint Council
of Allergy,
Asthma and
Immunology

Palatine, IL 60067
Voice: 847-934-1918
Fax: 847-934-1820
E-Mail: info@jcaai.org

August 18, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard - Mail Stop C4-26-05
Baltimore, Maryland 21244-8017

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

Dear Dr. McClellan:

The Joint Council of Allergy, Asthma and Immunology (JCAAI) is pleased to have this opportunity to comment on the *Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and the Proposed Changes to the Practice Expense Methodology* as published in the June 29, 2006 Federal Register.

JCAAI is an organization sponsored by the American Academy of Allergy, Asthma and Immunology and the American College of Allergy, Asthma and Immunology. It represents the interests of over 3,000 physicians board-certified in allergy and immunology.

JCAAI's Practice Expense Supplemental Survey

We are pleased that CMS is proposing to use, in the 2007 fee schedule, the supplemental practice expense survey completed by JCAAI in 2005 and submitted to CMS last year. JCAAI has also elected to participate in the multi-specialty survey being carried out under the auspices of the AMA. We believe it is important that this survey be required to meet the same criteria with respect to statistical validity and precision that JCAAI and other specialties had to meet in conducting supplemental surveys. We urge that CMS work with the AMA and physician community to ensure that these criteria are included as this process moves forward.

Change to Bottom-Up Methodology

We support CMS' proposal to change to a bottom-up methodology for determining direct practice expense RVUs. We believe this is a more rational approach. We are concerned, however, that there must be an ongoing mechanism for updating direct practice expense costs either through the RUC or some other mechanism. The cost of equipment and supplies changes frequently. New technology can result in higher costs; at the same time the cost of new technology frequently decreases as the equipment becomes more established. Further, sometimes federal regulatory requirements impose new requirements on physicians. There needs to be a mechanism or process to address changes of this type just as there is for physician work.

Allocation of Indirect PE RVUs

We support CMS' proposal to use clinical labor time to allocate indirect PE RVUs for codes with no physician work or for which physician work RVUs are lower than clinical labor RVUs. We believe this is important in creating a level playing field for technical component codes or codes with very low work RVUs.

Sponsoring Organizations:
American Academy of Allergy, Asthma and Immunology
American College of Allergy, Asthma and Immunology

Board of Directors:
Stanley M. Fineman, MD, MBA *President*
Robert A. Nathan, MD *President-Elect*
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Dennis R. Ownby, MD
Nicholas A. Pawlowski, MD
Thomas A. E. Platts-Mills, MD
F. Estelle R. Simons, MD
James L. Sublett, MD

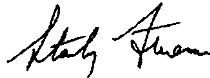
Robert J. Becker, MD *Consultant*

Donald W. Aaronson, MD *Executive Director*

We are concerned, however, about CMS' decision to continue to use physician work as an allocator for indirect costs. We believe physician time bears a much more direct relationship to indirect costs than physician work. Intensity of work has little connection to overhead costs, such as rent, utilities and clerical staff. Why should a surgical procedure performed in the office receive a higher allocation of overhead expenses than an evaluation and management service that takes a similar amount of time? Using work RVUs rather than physician time to allocate indirect costs unfairly advantages procedural specialties at the expense of those who provide more time-consuming cognitive services. We believe this is an inequity that should be corrected.

We appreciate the opportunity to comment on this proposed notice. If you have any questions, please contact our Washington representative, Rebecca Burke, at 202-466-6550.

Sincerely,



Stanley Fineman, MD, MBA
President

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

Organization : The Heart Health Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1811-Attach-1.TXT

Attach # 1811

August 18, 2006

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

RE: Proposed Notice Regarding 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 Regarding Practice Expense

Dear Mr. McClellan:

On behalf of The Heart Health Center and our seven 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 practice.

The proposed approach is biased again 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 93501 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	Right and Left 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, 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 Medial Association's RVS Update Committee ("RUC") and reflect the direct costs of clinical labor, medical supplied 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 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 results 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 results, 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—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 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 catheterizations 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 more 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,

Allen D. Soffer, M.D., F.A.C.C.
The Heart Health Center

ADS/ckh

CMS-1512-PN-1812 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Ms. Darlene Racz** **Date & Time:** **08/18/2006**

Organization : **Turner Geriatric Clinic**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Please do not reduce work values by 7% for clinical social workers effective January 1, 2007. As the great majority of patients receive their mental health services through social workers, this action could adversely impact persons' access to appropriate mental health services. The "top down" formula used to calculate practice expense has a negative impact on mental health providers.

CMS-1512-PN-1813 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Mrs. Kathryn Hall** **Date & Time:** **08/18/2006**

Organization : **Yellowstone City-County Health Department**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

I am in favor of increasing provider reimbursement for HIV patient visits. In order to keep patients in medical care, helping them be adherent with their medication regimen, adequate provider time must be taken into consideration. Many patients with HIV/AIDS infection are homeless, mentally ill, have substance abuse issues and need more time for provider interaction. Providers are leaving the field due to the time demand for their services and inadequate reimbursement for the time that is required to do "good" HIV/AIDS care.

CMS-1512-PN-1814 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Ms. Kay Karcher** **Date & Time:** **08/18/2006**

Organization : **Breast Care Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

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

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

We recommend that CMS withdraw its proposed reduction for the technical component of CAD until such time that providers can differentiate between the utilization of CAD with analog or digital mammography. The CPT codes for CAD with mammography (76082, 76083) contain the phrase, "with or without digitization of film radiographic images".

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

Thank you for your attention to this comment on behalf of the Breast Care Center in Mount Vernon, WA

CMS-1512-PN-1815 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Ms. Lisa Friedman** **Date & Time:** **08/18/2006**

Organization : **Lisa Friedman, LCSW, Inc**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern:
I am a private clinical social worker and if there is a decrease in medicare reimbursement I will have to cease serving the medicare population. It is quite expense to keep a private practice running with rent, electric, etc. Any decrease in reimbursement decreases the private practioners ability to see insured clients. I specialize in trauma, grief, and medical issues, therefore I work with a number of medicare eligible clients. Their needs will not be met in the private practice sector due to proposed changes in reimbursement.
I hope you receive information from multiple practioners so that you can see how your newest proposal to decrease reimbursement rates will severely impact the mental health community clients and providers.

Thank you for your time,
Lisa Friedman, LCSW
Licensed Clinical Social Worker
Registered Voter in Florida

CMS-1512-PN-1816 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Mrs. Laurie Bell** **Date & Time:** **08/18/2006**

Organization : **Fairview Red Wing Health Services**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

August 18, 2006

Dear Dr. McClellan,

I am a physical therapist who currently manages a rehab department in Red Wing, Minnesota. I have practiced for 23 years.

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

I would urge CMS to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007 and I recommend that CMS transition the changes to work relative value units over a four year period to ensure that patients continue to have access to valuable health care services. These proposed cuts undermine th goal of having a Medicare payment system that preserves patient access and achieves greater quality fo care. If payment for these services is cut so severely, access to care for millions of the elderly and disabled will be jeopardized.

Thank you for your consideration in the matter.

Sincerely,

Laurie Bell P.T.

CMS-1512-PN-1817 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Mrs. Brenda Kraft** **Date & Time:** **08/18/2006**

Organization : **Mercy Hospital**

Category : **Other Technician**

Issue Areas/Comments

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

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

August 17, 2006

Dear Centers for Medicare & Medicaid Services,

It is has come to my attention that there are proposed changes to the Medicare Physician Fee Schedule regarding the reimbursement for DXA scans.

There are many reason this would adversely affect patient care. With the proposed decrease in reimbursement, it will be impossible for medical centers to justify the purchase of new equipment, and make it economically infeasible for our institution to continue providing the service.

In the absence of affordable systems to provide recommended screening services, some physicians may revert to the use of less expensive technologies, such as peripheral DXA. This procedure is specifically not recommended for diagnostic use according to all guidelines and will not yield the accurate information needed to determine appropriate therapeutic regimens.

I have a personal connection with this disease. My grandmother suffered from the effects of osteoporosis. She was of advanced age before she found out she had osteoporosis. Had she been screened at a younger age, she may not have had to suffer from multiple vertebral and pelvic fractures. Because of her fractures she had to be admitted to a nursing home. Her health declined rapidly and she eventually died. If she had known of her osteoporosis earlier she could have been on treatment to gain bone density to prevent her fractures that lead to her death, and her overall health care costs would have been reduced.

If patients are not given the opportunity to be screened for osteoporosis or have inadequate screens, their overall costs of their individual health care will rise. If patients are denied access to DXA scans to help prevent fractures, they will be more at risk to suffer from fractures, which may lead to surgery, hospital stays, nursing home stays, and early death. The costs of not screening and treating patients with osteoporosis would be far greater than if patients could have a DXA scan and begin to build their bone density. They then could enjoy longer healthier lives.

I hope with my letter these proposed changes will not go into effect, in fact I would hope that there could be a campaign started to make people more aware of the detrimental effects osteoporosis has on their overall health. Patients should be offered state of the art DXA scans and be put on treatment if necessary. Overall health care costs will drop dramatically and people will enjoy longer healthier lives.

Sincerely,

Brenda Kraft
Radiology Department
Mercy Hospital
1031 7th ST NE
Devils Lake, ND 58301

Submitter :

Date: 08/18/2006

Organization : **Consultants in Cardiology**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

See Attachment

CMS-1512-PN-1818-Attach-1.PDF

Attachment # 1818

Robert S. Capper, MD, FACP, FACC, Emeritus
Billie R. Pugh, Jr., MD, FACC
William S. Vance, Jr., MD, FACC
John L. Durand, MD, FACC
Wade McBride, MD, FACC
R. Dale Anderson, MD, FACC
David D. Corley, MD, FACC
John E. Willard, MD, FACC
David L. Parrish, MD, FACC
Sreenivas Gudimetla, MD, FACC
Joseph M. Ortenberg, MD, FACC
Robert S. Meidell, MD
Audrey H. Rapp, MD
Theodore S. Takata, MD, FACC
David P. Capper, MD
Ann Teal, PA-C
Mark Jackson, PA-C

August 18, 2006

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

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

Dear Mr. McClellan:

On behalf of Consultants in Cardiology (CIC) and our thirteen 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.

As a part of the office practice, CIC has operated a cardiac catheterization laboratory for many years. We perform approximately 700 cases a year, about half of which are Medicare patients.

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.

1300 West Terrell . Suite 500 . Fort Worth . Texas . 76104 817.252.5000
6100 Harris Parkway . Plaza 120 . Fort Worth . Texas . 76132 817.263.3724
Outpatient Diagnostics Fax 817.252.5097 Business Fax 817.252.5096 Nurses Fax 817.252.5086

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	•1 Direct Patient Care For Activities Defined by RUC •2 Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	•3 Direct Patient Care For Activities Not Defined by RUC •4 Actual Staff Allocation Based on Patient Needs
Medical Supplies	•5 Supplies Used For More Than 51% of Patients	•6 Supplies Used For Less Than 51% of Patients
Medical Equipment	•7 Equipment Used For More Than 51% of Patients	•8 Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	•9 Approximately 55% of the direct costs are included in the RUC estimate	•10 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.

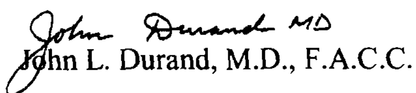
We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted

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.

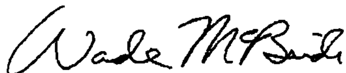
Sincerely,

Billie R. Pugh, Jr., M.D., F.A.C.C.

William S. Vance, Jr., M.D., F.A.C.C.



John L. Durand, M.D., F.A.C.C.



Wade McBride, M.D., F.A.C.C.

R. Dale Anderson, M.D., F.A.C.C.

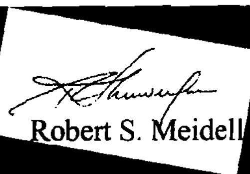
David D. Corley, M.D., F.A.C.C.

John E. Willard, M.D., F.A.C.C.

David L. Parrish, M.D., F.A.C.C.

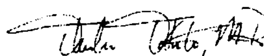
Sreenivas Gudimetla, M.D., F.A.C.C.

Joseph M. Ortenberg, M.D., F.A.C.C.



Robert S. Meidell, M.D.

Audrey H. Rapp, M.D.



Theodore S. Takata, M.D., F.A.C.C.

/ps

CMS-1512-PN-1819

Submitter : Mrs. Cynthia Matchinsky

Date: 08/18/2006

Organization : Cambridge Medical Center

Category : Other Technician

Issue Areas/Comments

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

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

see attachment

CMS-1512-PN-1819-Attach-1.DOC

CMS-1512-PN-1819-Attach-2.DOC

Attach #
1819

To Whom It May Concern

Regarding the proposed changes to the Medicare Physician Fee Schedule- file code CMS-1512-PN

Cuts in the DXA reimbursement as proposed will negatively impact women's access to this important test. As you know, research has proven that low bone mineral density correlates with the risk for osteoporotic fractures. Identifying patients at risk for osteoporosis with DXA enables the patient to start drug therapy to rebuild bones and prevent fractures. A bone density study at the cost of $150.00 is far more economical than $30,000.00 for hip repair surgery. Not to mention, the consequent pain and suffering, burdens and possible deaths as a result of these fractures.

For facilities performing DXA, current reimbursement costs are barely covering our programs. The cost of fan beam technology to provide state of the art osteoporosis screening, along with maintenance, technologist's wages, reports, educational material and patient follow up all need to be considered. It would be doing a great disservice to the public if quality DXA centers are closed due to operating costs exceeding reimbursement rates.

Cynthia Matchinsky
Lead DXA Technologist
Cambridge Medical Center

CMS-1512-PN-1820 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Mrs. Cheryl Swann** **Date & Time:** **08/18/2006**

Organization : **West Volusia Medical Assoc.,P.A.**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

Re: Medicare RVU increase

To Whom It May Concern:

I am writing to express support for the Centers for Medicare and Medicaid Services recommendation to increase RVUs for E/M services.

Physicians who have provided E/M services during the last 10 years are well aware that the complexity of providing these services has increased dramatically. There are several reasons why this has occurred. Medical technology has provided a much broader array of treatments that need to be considered during the course of patient care. We have more pharmaceuticals to choose from, and more procedures to consider. In addition, patients have become more medically sophisticated and are interested in discussing their treatment options more thoroughly with their physicians. Also, the average patient is living longer and has accumulated more treatable illnesses, thus increasing the complexity of a patient-physician encounter even more. Unquestionably, managing a Medicare patient today involves a significantly greater effort than was the case a decade ago.

In order to ensure that Medicare patients receive the best possible E/M services, it will be necessary to provide physicians with reimbursements that reflect their increased workload. I wholly support the proposed changes in work RVUs. The resulting improvement in reimbursements will help to maintain the high quality of care we expect for our Medicare population.

Sincerely,

Cheryl W. Swann, Administrator
West Volusia Medical Associates, P.A.
1070 N. Stone Street, Suite A
DeLand, FL 32720

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

Organization : **Cardiovascular Institute of Southern Oregon, LLC**

Category : **Other Health Care Provider**

Issue Areas/Comments

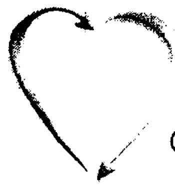
GENERAL

GENERAL

see attachment

CMS-1512-PN-1821-Attach-1.TXT

Attach # 1821



CardioVascular Institute
of Southern Oregon, LLC

August 17, 2006

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

Dear Dr. McClellan:

On behalf of Cardiovascular Institute of Southern Oregon, LLC and our 16 practicing cardiologists and 6 practicing vascular surgeons, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

Cardiovascular Institute of Southern Oregon, LLC (CVISO) is a freestanding outpatient facility dedicated to the delivery of high quality cardiac catheterization and peripheral angiography procedures. CVISO is classified with CMS as an Independent Diagnostic Testing Facility (IDTF). It is a service developed after lengthy planning and evaluation. The facility is an equal joint venture between the area's two cardiology practices, Cardiology Consultants, PC and The Heart Clinic of Southern Oregon and Northern California, PC; Oregon Surgical Specialists, PC, the principal vascular surgery practice in our region; and Asante Health System, which owns Rogue Valley Medical Center. These groups provide cardiovascular diagnostic, interventional and surgical services for patients residing in the Southern Oregon and Northern California region. The service area spans a radius of greater than 100 miles. We have served upwards of 3700 patients in our two state-of-the-art cath labs over our 2 ½ years of operation. The Southern Oregon/Rogue Valley area is rapidly growing and has been repeatedly reported in lists of top ten desirable locations for retirement. This leads to a patient population that has an increased need for cardiac care. Having the ability to perform a subset of elective cardiac procedures on stable patients in a safe, efficient outpatient environment increases the availability of hospital resources, both physical and human, for the acute and emergent patient. The proposed reductions in PE RVU will significantly affect our ability to provide these services for Medicare and all other patients.

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 that the proposed methodology has 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.

520 Medical Center Drive Suite 150, Medford, Oregon 97504-4312 (541) 282-6660

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	Ventriculography
93556-TC	Coronary Artery Angiography
93526-TC	Combined Right and Left Heart Catheterization
75605-TC thru 75999-TC	Invasive Diagnostic Angiography

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 we believe were submitted by the Society for Cardiovascular Angiography and Interventions ("SCAI") through the American College of Cardiology. 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 to the RUC, 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 not 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 the 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 that do not reflect the cost profile of cardiac catheterization facilities. Instead, cardiac catheterization facilities may have a cost profile similar to

cardiology in terms of the higher indirect costs that are associated with performing these services. **As our IDTF performs only invasive, angiography services, our average indirect costs are not diluted by lower technology studies that may be performed in a general service outpatient imaging IDTF.**

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 and safely. 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 and angiography 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 catheterizations 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 more accurate 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 to evaluate the impact of the PE RVU methodology on our practices.

Sincerely,

Wendy Perston
Administrative Director
(541) 282-6670
wendyp@cviso.com

CMS-1512-PN-1822 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Dr. Sundeep Reddy** **Date & Time:** **08/18/2006**

Organization : **Lorenzo R. Pelly, M.D.**

Category : **Physician**

Issue Areas/Comments

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

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

The proposal to reduce the reimbursement for the dual ebergy x-ray absorptiometry will have a great negative impacted to the sevices we provided to our elderly patients. In order to provided our patients (especially elderly women) osteoporosis sceening we ask you not to reduce the reimbersement rate.

Sincerely,
Amar Bagepalli, M.D.
Sundeep Reddy, M.D.
Lorenzo R Pelly, M.D.

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

Organization : **Cambridge Medical Center**

Category : **Other Technician**

Issue Areas/Comments

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

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

see attachment

CMS-1512-PN-1823-Attach-1.DOC

Attach #
1823

To Whom It May Concern

Regarding the proposed changes to the Medicare Physician Fee Schedule- file code CMS-1512-PN

Cuts in the DXA reimbursement as proposed will negatively impact women's access to this important test. As you know, research has proven that low bone mineral density correlates with the risk for osteoporotic fractures. Identifying patients at risk for osteoporosis with DXA enables the patient to start drug therapy to rebuild bones and prevent fractures. A bone density study at the cost of $150.00 is far more economical than $30,000.00 for hip repair surgery. Not to mention, the consequent pain and suffering, burdens and possible deaths as a result of these fractures.

For facilities performing DXA, current reimbursement costs are barely covering our programs. The cost of fan beam technology to provide state of the art osteoporosis screening, along with maintenance, technologist's wages, reports, educational material and patient follow up all need to be considered. It would be doing a great disservice to the public if quality DXA centers are closed due to operating costs exceeding reimbursement rates.

Cynthia Matchinsky
Lead DXA Technologist
Cambridge Medical Center

CMS-1512-PN-1824 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Mrs. Carolyn Hamlin** **Date & Time:** **08/18/2006**

Organization : **Covenant Health care**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I have been involved with health care for 12 yrs as a clerical associate/aid for radiology. I have been in the rooms with the techs to help them move an elderly patient with a hip fracture, caused by osteoporosis,onto an x-ray table. The pain for them is unbelievable and my heart goes out to hem every time. I have then followed the x ray tech to the recovery rooms in OR for their follow up films. I have seen them spend weeks in the hospital due to complications from pain, osteoporosis and pnuemonia.

I cant even imagine the amount of pain and anguish that could have been prevented if these patients would have had any type of bone density testing when a difference could have been made.

If you implement dramatic reimbursement cuts for bone density tests our needy and elderly patients will not have the test done. How can you think that cutting an inexpensive test with a reimbursement of $140 willhelp you save money when osteoporotic related fracures alone cost the U.S. millions of dollars a year.

If you cut the reimbursement ot $40 most Dr. offices, clinics, and hospitals will no longer be able to offer bone densiy testing.

Bone Density testing is still significantly under utilized. The prevention of full blown osteoporosis and its related fractures and health problems far out weigh the cost of the test itself.

Please recondider any cuts made for bone density testing. OUr elderly and our poor are counting on us.

Thank you

Carolyn Hamlin
Saginaw, Mighigan

CMS-1512-PN-1825 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

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

Organization : **Medical Imaging Systems, Inc**

Category : **Individual**

Issue Areas/Comments

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

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

We recommend that CMS withdraw its proposed ereduction for the technical component of CAD until such time that providers can differentiatebetween the utilization of CAD with analog or digital mammography. The CPT codes for CAD with mammography (76082, 76083) contain the phrase, "with or without digitization of film radiopgraphic images".

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

Sincerely,

Stephen W. Firmender

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

Organization : **Bellevue and Seattle Heart & Vascular Centers**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1826-Attach-1.DOC

Attach# 1826

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

August 18, 2006

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 Bellevue Heart and Vascular, Seattle Heart and Vascular Center, and, our thirty 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.

As a cardiovascular network of thirty cardiovascular specialists, we represent two cardiovascular IDTF's serving the community of Western Washington. We are the largest provider in the region of outpatient cardiovascular diagnostic services, providing over two thousand patients with diagnostic procedures per year.

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

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

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

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

Direct Costs

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

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

inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

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

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

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

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

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

Indirect Costs

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

John K. Hynes, M.D.

Medical Director

Bellevue Heart and Vascular Center

Seattle Heart and Vascular Center

2701 1st Ave Ste 320

Seattle, WA 98121

206-281-8160

CC: Senia Hussong, Chief Administrative Officer

Jay Bohreer, Chief Executive Officer

CMS-1512-PN-1827 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Dr. harry malcolm** **Date & Time:** **08/18/2006**

Organization : **duluth clinic**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

I am a rural primary care physician working in a reasonably desirable area to live, an area where we should not have great difficulty recruiting to. We are in an area that is growing relatively rapidly, has good medical and comnmunity facilities, and to which a growing number of individuals are moving to post retirement. Unfortunately, in the last two years we have lost 3 physicians and are now trying to recruit 5 physicians, to date without avail. This is resulting in overall poorer primary medical care (more ER visits, more medical breakdowns and admissions, and a growing number of people deciding simply not to treat significant medical issues such as diabetes or HTN as its to difficult to get an apt) and also increasing the risk of burn out for the remaining providers. Apparently there are now over 700 primary care MD/DO job openings in Wisconsin alone, and people to fill these jobs simply don't exist. Finances are the primary reason for this shortfall/crisis. I work in the hospital and clinic an average of 65 hours a week and am constantly evaluating people on the side when I'm shopping or at community events. If I was a specialist (radiologist/cardiologist/any medical or surg subspecialty/dermatologist/ect) my salary would more then double and I would work fewer hours. Residents and med students are aware of this disparity and are therefore often shying away from primary care careers...where they are most needed. More specialists performing more tests and procedures is simply going to bankrupt our medical system and ultimately our country. We need to alter reimbursemt so that we are reimbursed more to spend appropriate time with patients as a primary care provider, and help improve the overall health of our population. As a primary care provider, I strongly support the proposed revisions to the RVU system as part of an overall effort to redirect medical resources and encourage prevention and control of medical issues as opposed to spending an ever growing percentage of our health care dollars on procedural interventions that often have no long term benifit. Thank you for reading my comments. I welcome questions. Sincerely, Harry Malcolm, MD

CMS-1512-PN-1828 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Dr. Gary Halversen** **Date & Time:** **08/18/2006**

Organization : **Western Neurological ASsociates, Inc.**

Category : **Radiologist**

Issue Areas/Comments

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

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

We recommend that CMS withdraw its proposed reduction for the technical component of CAD until such time that providers can differentiate between the utilization of CAD with analog or digital mammomgraphy. The CPT codes for CAD with mammography (76082, 76083) contain the phrase, "with or without digitation of film radiographic images". These revisions reflect chcanges in medical practice, coding changes, new data on RVS components, and the addition of new procedures that affect the relative amount of physician work required to perform each service as required by statute." There have been no changes to substantiate this proposed rule for the use of CAD with analog mammography.

CMS-1512-PN-1829 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

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

Organization : **PRB Innovative Consultations**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am writing concerned that the suggested reduction in the Clinical Social Worker rate for Medicare will result in lack of access to services for some of the most vulnerable citizens in the USA. Elderly and disabled patients with only Medicare benefits are unable to travel distances to receive services. Clinical Social Workers provide 80% of the mental health services in this country and these are provided at a rate that is barely acceptable now. Usually their costs are lower than all other professionals providing mental health services. Costs of providing services are going up and those costs include travel costs if the services are offered in the home or only at isolated outpatient clinics. Clinical Social Workers need to maintain their own health and need acceptable health care to be able to continue to provide service. In short, the cost of service is going up and clinical social workers have no way to absorb these costs, especially if the rate is reduced. Clnical social workers cannot tolerate a rate reduction and the health care system in the USA cannot tolerate a reduction in accessibility to this economical health care.

CMS-1512-PN-1830 Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

Submitter : **Dr. Diane Ranes** **Date & Time:** **08/18/2006**

Organization : **Carolina Partners in Mental Health Care, PLLC**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

I have a Doctorate in Clinical Social Work and in spite of training identical to PHD psychologists (at New York University) and 30 years of practice, I have been paid at a masters level by Federal standards that are antiquated.

Social Workers provide most of the mental health care in this nation, and our rates have been continuously held well under psychologists for the past 12 years. Moreover, our doctoral clinical social workers are not even recognized.

We provide the EXACT same service, see more underprivildeged and poor adults, families and children than do our psychologist peers. Hence, forcing practicioners like myself to stop working with Medicare and Medicaid is limiting access to service for many people.

This latest change will drive many of my fellow social workers and myself out of practice as we cannot cover our office costs. I already turn over 60% of a dwindling salary. If I were starting into the 'profession' now, I would be unable to support a family. The Federal changes proposed will devastate the profession.

One cannot help but wonder as years ago, working with my MD partners, I was paid equivalently to them for the same services, how this discrimination has evolved? Is it because the profession is mostly women? Or that our MD partners can no longer legally bill insurance carriers for our services in group practices even though they used to certify in that manner the high quality of practice?

In any case, our PHD clinical practictioners should be EQUAL to doctoral psychologists in pay at the very least. More directly, reform is needed so that all mental health practictioners providing codes of services are paid equally for delivering that same service code. As a member of a group practice who collaborates with MD's, Psychologist PHD's, Nurse Practicioners, and others, I know that these differences in quality of care are non- existant.

This particular proposed change will harm clients, providers and the services.

I already am paid 25% or more lower than other Phd's, and, now will be paid another 14% lower. Since rates have been steady without adjustment for inflation for years, I will be forced to discontinue service to the very population my profession sought to help in its inception.

These changes are disastrous to Medicaid and Medicare clients not only for myself, but for many masters social workers whom I supervise as they treat your populations.

I am a member of NASW and the Clinical Social Work Federation.

Please, equalize our PHD's, and in reality, all providers using the same service codes should be paid identically. One does not pay a family practice physican less than an internist just because of slight variations in their original training. Isn't it time we simply worked with a single rate and looked at outcomes?

Thank you.

Submitter : **Mr. Tommy Thornton** **Date: 08/18/2006**

Organization : **Hattiesburg Clinic, P.A.**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Comments provided as an attachment.

CMS-1512-PN-1831-Attach-1.DOC

Attach # 1831

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

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

Dear Mr. McClellan:

On behalf of Hattiesburg Clinic, P.A. and our 10 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.

Hattiesburg Clinic is a 200+ physician multi-specialty clinic located in Hattiesburg, Mississippi serving more than 400,000 residents of the south Mississippi area. Annually we perform over 2,500 heart catheterizations and related procedures.

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
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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,

Tommy G. Thornton, FACMPE
Executive Director
Hattiesburg Clinic, P.A.

Submitter : **Mr. Richard Johnson**

Date: 08/18/2006

Organization : **Mercy Hospital**

Category : **Radiologist**

Issue Areas/Comments

GENERAL

GENERAL

see attachments

CMS-1512-PN-1832-Attach-1.PDF

Attach
1832

August 17, 2006

Dear Centers for Medicare & Medicaid Services,

It is has come to my attention that there are proposed changes to the Medicare Physician Fee Schedule regarding the reimbursement for DXA scans.

There are many reason this would adversely affect patient care. With the proposed decrease in reimbursement, it will be impossible for medical centers to justify the purchase of new equipment, and make it economically infeasible for our institution to continue providing this service.

In the absence of affordable systems to provide recommended screening services, some physicians may revert to the use of less expensive technologies, such as peripheral DXA. This procedure is specifically not recommended for diagnostic use according to all guidelines and will not yield the accurate information needed to determine appropriate therapeutic regimens.

If patients are not given the opportunity to be screened for osteoporosis or have inadequate screens, their overall costs of their individual health care will rise. If patients are denied access to DXA scans to help prevent fractures, they will be more at risk to suffer from fractures, which may lead to surgery, hospital stays, nursing home stays, and early death. The costs of not screening and treating patients with osteoporosis would be far greater than if patients could have a DXA scan and begin to build their bone density. They then could enjoy longer healthier lives.

I hope with my letter these proposed changes will not go into effect, in fact I would hope that there could be a campaign started to make people more aware of the detrimental effects osteoporosis has on their overall health. Patients should be offered state of the art DXA scans and be put on treatment if necessary. Overall health care costs will drop dramatically and people will enjoy longer healthier lives.

Sincerely,

Radiology Department
Mercy Hospital
1031 7th ST NE
Devils Lake, ND 58301

[illegible] RT(R)
[illegible] ARRT
[illegible] RT(R) ARDMS
[illegible] RT(R)

August 17, 2006

Dear Centers for Medicare & Medicaid Services,

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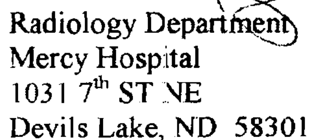
There are many reason this would adversely affect patient care. With the proposed decrease in reimbursement, it will be impossible for medical centers to justify the purchase of new equipment, and make it economically infeasible for our institution to continue providing this service.

In the absence of affordable systems to provide recommended screening services, some physicians may revert to the use of less expensive technologies, such as peripheral DXA. This procedure is specifically not recommended for diagnostic use according to all guidelines and will not yield the accurate information needed to determine appropriate therapeutic regimens.

If patients are not given the opportunity to be screened for osteoporosis or have inadequate screens, their overall costs of their individual health care will rise. If patients are denied access to DXA scans to help prevent fractures, they will be more at risk to suffer from fractures, which may lead to surgery, hospital stays, nursing home stays, and early death. The costs of not screening and treating patients with osteoporosis would be far greater than if patients could have a DXA scan and begin to build their bone density. They then could enjoy longer healthier lives.

I hope with my letter these proposed changes will not go into effect, in fact I would hope that there could be a campaign started to make people more aware of the detrimental effects osteoporosis has on their overall health. Patients should be offered state of the art DXA scans and be put on treatment if necessary. Overall health care costs will drop dramatically and people will enjoy longer healthier lives.

Sincerely,



Radiology Department
Mercy Hospital
1031 7th ST NE
Devils Lake, ND 58301

Submitter : **Dr. David Rice** **Date: 08/18/2006**

Organization : **Association of Freestanding Radiation Oncology Cen**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-1833-Attach-1.PDF

AH ach # 1833

AFROC

ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

Our Voice in Washington

September 30, 2005

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006 Payment Rates; CMS-1502-P; PE Proposals and NPWP Elimination

Dear Dr. McClellan:

On behalf of the Association of Freestanding Radiation Oncology Centers (AFROC), we are delighted to have the opportunity to submit these comments on the proposed CY 2006 Medicare Physician Fee Schedule Proposed Rule, set forth in the August 8, 2005 *Federal Register* notice (the Proposed Rule).

AFROC applauds CMS's proposal to accept AFROC's survey data and to "blend" the AFROC data with the data submitted by ASTRO to determine the PE/hr for radiation oncology. We have reviewed The Lewin Group's report on this issue and believe it to be reasonable.

We also support CMS's decision to use a "bottom up" methodology for determining direct costs. Eliminating the "scaling factors"--at least for direct costs--is a step in the right direction toward a simpler and more transparent practice expense methodology.

We do note that a number of radiation oncology technical component services would decrease under the Proposed Rule. This is especially true for brachytherapy services. See Attachment A, Tables 1 and 2. We request that CMS review the direct cost inputs for the services listed at Attachment A to ensure that all direct costs are taken into account.

Reductions of this magnitude are tenable only because the Proposed Rule would substantially increase Medicare payment for most daily treatment services. We understand that CMS will be considering a great many comments from the professional community during the course of the rulemaking proceedings. We note that if there are substantial reductions to the daily treatment code allowances set forth in the Proposed

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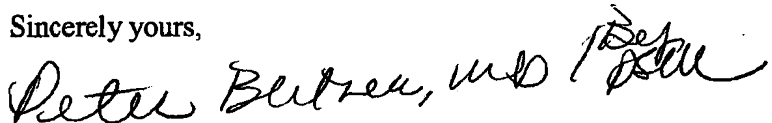
Rule as the result of the public comments, the proposed reductions in payment for the services set forth at Attachment A would become untenable. In that event, we would hope that CMS will consult with us about the possibility of capping the reductions that are implemented in CY 2006.

We also hope that CMS will consider modifying its methodology for maintaining budget neutrality for practice expense changes. It is our understanding that, under the current methodology, when the number of PE-RVUs changes as the result of the acceptance of new PE survey data or otherwise, budget neutrality is maintained by making across-the board reductions in the PE-RVUs. This has the impact of the distorting the relativity of various services and disadvantaging services that are comprised of practice expense relative value units, such as TC services performed by freestanding radiation oncology centers. We believe that it would be more appropriate to maintain budget neutrality with respect to PE-RVU changes by reducing the conversion factor or spreading the costs proportionately over all RVUs, whether they are PE-RVUs, W-RVUs, or malpractice-RVUs.

Again, we appreciate the opportunity to comment on the Proposed Rule. If you have any questions regarding AFROC's position on this matter, please do not hesitate to contact AFROC's Washington counsel, Diane Millman, at 202-87206725 (dmillman@ppsv.com)

Sincerely yours,



Peter Blitzer, M.D.
President, AFROC

Attachment A
Tables 1 and 2

CodeMod	Code	MOD	DESCRIPTION	2005 RVUs	Proposed 2006 RVUs	Change in Non-facility Total RVUs	% Change in Non-facility Total RVUs
7682526	76825	26	Echo exam of fetal heart	2.34	2.34	0.00	0.0%
76825	76825		Echo exam of fetal heart	4.42	4.91	0.49	11.1%
76825TC	76825	TC	Echo exam of fetal heart	2.08	2.57	0.49	23.6%
7682626	76826	26	Echo exam of fetal heart	1.15	1.15	0.00	0.0%
76826	76826		Echo exam of fetal heart	1.91	2.38	0.47	24.6%
76826TC	76826	TC	Echo exam of fetal heart	0.76	1.22	0.46	60.5%
7682726	76827	26	Echo exam of fetal heart	0.82	0.81	-0.01	-1.2%
76827	76827		Echo exam of fetal heart	2.66	2.45	-0.21	-7.9%
76827TC	76827	TC	Echo exam of fetal heart	1.84	1.64	-0.20	-10.9%
7682826	76828	26	Echo exam of fetal heart	0.81	0.81	0.00	0.0%
76828	76828		Echo exam of fetal heart	2.00	1.84	-0.16	-8.0%
76828TC	76828	TC	Echo exam of fetal heart	1.19	1.03	-0.16	-13.4%
9330326	93303	26	Echo transthoracic	1.82	1.84	0.02	1.1%
93303	93303		Echo transthoracic	5.91	6.32	0.41	6.9%
93303TC	93303	TC	Echo transthoracic	4.09	4.48	0.39	9.5%
9330426	93304	26	Echo transthoracic	1.06	1.06	0.00	0.0%
93304	93304		Echo transthoracic	3.13	3.61	0.48	15.3%
93304TC	93304	TC	Echo transthoracic	2.07	2.55	0.48	23.2%
9330726	93307	26	Echo exam of heart	1.30	1.32	0.02	1.5%
93307	93307		Echo exam of heart	5.39	5.48	0.09	1.7%
93307TC	93307	TC	Echo exam of heart	4.09	4.17	0.08	2.0%
9330826	93308	26	Echo exam of heart	0.75	0.76	0.01	1.3%
93308	93308		Echo exam of heart	2.82	3.08	0.26	9.2%
93308TC	93308	TC	Echo exam of heart	2.07	2.32	0.25	12.1%
9331226	93312	26	Echo transesophageal	3.07	3.10	0.03	1.0%
93312	93312		Echo transesophageal	7.14	8.45	1.31	18.3%
93312TC	93312	TC	Echo transesophageal	4.07	5.35	1.28	31.4%
93313	93313		Echo transesophageal	1.22	1.01	-0.21	-17.2%
9331426	93314	26	Echo transesophageal	1.77	1.78	0.01	0.6%
93314	93314		Echo transesophageal	5.84	6.91	1.07	18.3%
93314TC	93314	TC	Echo transesophageal	4.07	5.13	1.06	26.0%
9331526	93315	26	Echo transesophageal	3.90	3.92	0.02	0.5%
93315	93315		Echo transesophageal	0.00	0.00	0.00	#DIV/0!
93315TC	93315	TC	Echo transesophageal	0.00	0.00	0.00	#DIV/0!
93316	93316		Echo transesophageal	1.24	NA	#VALUE!	#VALUE!
9331726	93317	26	Echo transesophageal	2.58	2.60	0.02	0.8%
93317	93317		Echo transesophageal	0.00	0.00	0.00	#DIV/0!
93317TC	93317	TC	Echo transesophageal	0.00	0.00	0.00	#DIV/0!
9331826	93318	26	Echo transesophageal intraop	2.82	2.82	0.00	0.0%
93318	93318		Echo transesophageal intraop	0.00	0.00	0.00	#DIV/0!
93318TC	93318	TC	Echo transesophageal intraop	0.00	0.00	0.00	#DIV/0!
9332026	93320	26	Doppler echo exam, heart	0.54	0.55	0.01	1.9%
93320	93320		Doppler echo exam, heart	2.37	2.43	0.06	2.5%

93320TC	93320	TC	Doppler echo exam, heart	1.83	1.88	0.05	2.7%
9332126	93321	26	Doppler echo exam, heart	0.22	0.22	0.00	0.0%
93321	93321		Doppler echo exam, heart	1.41	1.31	-0.10	-7.1%
93321TC	93321	TC	Doppler echo exam, heart	1.19	1.09	-0.10	-8.4%
9332526	93325	26	Doppler color flow add-on	0.11	0.11	0.00	0.0%
93325	93325		Doppler color flow add-on	3.22	2.70	-0.52	-16.1%
93325TC	93325	TC	Doppler color flow add-on	3.11	2.59	-0.52	-16.7%
9335026	93350	26	Echo transthoracic	2.10	2.12	0.02	1.0%
93350	93350		Echo transthoracic	3.99	5.02	1.03	25.8%
93350TC	93350	TC	Echo transthoracic	1.89	2.90	1.01	53.4%

CPT Code	Descriptor	2005 RVU	2006 Proposed RVU	2009 Proposed RVU	2005-2006 RVU Change	2005-2009 RVU Change
77295	3D Simulation	35.67	30.60	15.20	-14.2%	**-57.4%**
77300	Basic Dosimetry Calculation	2.26	2.21	2.04	-2.2%	-9.7%
77305	Simple Isodose Plan	2.94	2.68	1.88	-8.8%	**-36.1%**
77310	Intermediate Isodose Plan	3.90	3.59	2.66	-7.9%	**-31.8%**
77315	Complex Isodose Plan	4.94	4.75	4.17	-3.8%	**-15.6%**
77321	Special Teletherapy Port Plan	5.55	4.89	2.90	-11.9%	**-47.7%**
77333	Intermediate Treatment Devices	3.15	2.78	1.64	-11.7%	**-47.9%**
77334	Complex Treatment Devices	5.12	5.02	4.70	-2.0%	-8.2%
77336	Continuing Medical Physics Consult	3.14	2.73	1.44	-13.1%	**-54.1%**
77370	Special Medical Physics Consult	3.67	3.63	3.43	-1.1%	-6.5%
77401	Superficial Radiation Treatment Delivery	1.88	1.64	0.89	-12.8%	**-52.7%**
77417	Radiology Port Films	0.63	0.60	0.48	-4.8%	**-23.8%**
77418	IMRT Treatment Delivery	18.15	16.84	12.81	-7.2%	**-29.4%**
77470	Special Treatment Procedure	14.61	12.32	5.36	-15.7%	**-63.3%**
77781	HDR Brachytherapy; 1-4 catheters	23.63	19.79	8.15	-16.3%	**-65.5%**
77782	HDR Brachytherapy; 5-8 catheters	24.78	23.24	18.49	-6.2%	**-25.4%**

Table 2 Brachytherapy Related Procedure Codes with Reductions in RVUs 2006 and 2009 (Bold text indicates reductions greater then 15% in 2009)

CPT Code	Descriptor	2005 RVU	2006 Proposed RVU	2009 Proposed RVU	2005-2006 RVU Change	2005-2009 RVU Change
19296	Delayed Breast Interstitial Radiation Treatment	129.38	121.96	98.81	-5.7%	**-23.6%**
19298	Placement Afterloading Brachytherapy Catheters Into Breast	48.59	46.00	37.94	-5.3%	**-21.9%**
76965	Ultrasound Guidance for Interstitial Radioelement Application	7.71	6.57	3.14	-14.8%	**-59.3%**