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

Organization : Idaho Cardiology Associates

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I wish to comment on the proposed changes to the PE methodology.

CMS-1512-PN-1881-Attach-1.DOC

ATTACHMENT TO #1881

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

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

Dear Dr. McClellan:

On behalf of Idaho Cardiology Associates, I 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.

Idaho Cardiology Associates, P.A. is the largest cardiology group practice in Idaho consisting of sixteen (16) cardiologists providing board-certified and fellowship trained invasive, interventional and electrophysiological services. Since its development in 2002, the physicians have owned and operated ICA Cath Lab, LLC, an independent diagnostic testing facility (IDTF) in which over 800 high quality, low cost diagnostic cardiac catheterization procedures are performed annually. Our patients, many of whom are Medicare beneficiaries, universally and enthusiastically relate a very high degree of satisfaction with the services and care provided to them at ICA Cath Lab. On their behalf we are very concerned with the proposed changes to the practice expense methodology.

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

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

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

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

Direct Costs

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

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

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

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

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

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

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

Indirect Costs

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

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

Solutions

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

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

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

Respectfully,

David A. Hinchman, MD, FACC

Submitter : **Mrs. ELIZABETH SNYDER** **Date: 08/18/2006**

Organization : **PRIMARY CARE ASSOCIATES, PC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

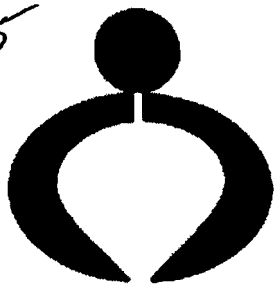
Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1885-Attach-1.DOC

ATTACHMENT TO # 1885



PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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

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

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

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

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

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

It is extremely important to realize that even though the software provides a mechanical interpretation for the scan this information is often incorrect if the physician does not properly evaluate the information. Ms. Jones was a 75-year-old woman with osteoarthritis at the lumbar spine and osteoporotic values at the neck of the bilateral hips. Without careful history and interpretation a falsely elevated total spine would be reported as normal and the total hips would be reported as osteopenic. When one couples her maternal history of hip fracture with the values at the neck region of her hips, the patient required treatment for osteoporosis.

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Elizabeth Snyder, APRN, BC
Primary Care Associates

Submitter : Mr. Joseph Lentol **Date:** 08/18/2006

Organization : New York State Assembly

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-1886-Attach-1.TXT

ATTACHMENT TO #1886

THE ASSEMBLY
STATE OF NEW YORK
ALBANY

JOSEPH R. LENTOL
Assemblyman 50th District
Kings County

PLEASE REPLY TO:
□ District Office:
619 Lorimer Street
Brooklyn, New York 11211
(718) 383-7474

□ Albany Office:
Room 632, L.O.B.
Albany, New York 12248
(518) 455-4477

e-mail:
lentolj@assembly.state.ny.us

Chairman
Committee on Codes

COMMITTEES
Rules
Ways & Means
Ethics and Guidance
Election Law

August 18, 2006

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

Dear Dr. McClellan:

I am writing to express my concerns over your proposed cuts to reimbursement for Computer Assisted Detection (CAD) for mammography and for DXA scans for osteoporosis.

The issue of osteoporosis and breast cancer is a priority for me as an individual and a legislator. Over the last decade, the New York State Legislature has made great strides in improving the deliver of women's heath services and raising state government awareness. I am appalled to learn of the recommendations for reimbursement cuts for screening technologies. I assure you, these cuts will have dramatic negative consequences for women's health.

Moreover, these proposed cuts will not achieve any savings in either federal, state. local health providers or health insurers' budgets. Many women will not receive early detection, but will still get cancer or osteoporosis. The treatment costs of these diseases increase during the later stages of the diseases.

Broken bones as the result of osteoporosis can result from minor falls. Nursing home care is the largest part of the New York State Medicaid budget. Nursing home care becomes necessary for older women living alone who are injured in falls. Breast cancer is the second leading cause of cancer deaths among American women and osteoporosis continually affects

THE ASSEMBLY
STATE OF NEW YORK
ALBANY

JOSEPH R. LENTOL
Assemblyman 50th District
Kings County

PLEASE REPLY TO:
□ District Office:
619 Lorimer Street
Brooklyn, New York 11211
(718) 383-7474

□ Albany Office:
Room 632, L.O.B.
Albany, New York 12248
(518) 455-4477

e-mail:
lentolj@assembly.state.ny.us

Chairman
Committee on Codes

COMMITTEES
Rules
Ways & Means
Ethics and Guidance
Election Law

millions of our aging population. Restricting funding for breast cancer and osteoporosis prevention is especially shortsighted.

When younger women suffer from these diseases, foster care expenditures may result as children need to be placed in the more advanced stages of these diseases. That is a significant expense for local governments everywhere.

These are just some of the reasons that these proposed cuts do not make financial sense. Of course, the human cost and the quality of life implication are more difficult to calculate. I hope you consider these factors as well before eliminating payment for advances in early detection.

For these reasons, I strongly urge you to not cut funding to CAD for mammography and for DXA scans for osteoporosis.

Thank you for your attention in this matter.

Sincerely,

Joseph R. Lentol
Assemblyman, 50th A.D.

Cc: Assemblymember Susan V. John

Submitter : Mrs. Jacque Sousley **Date: 08/18/2006**

Organization : Bothwell Diagnostic Center

Category : Rural Health Clinic

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

August, 11, 2006

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

RE: CMS-1512-PN

To Whom It May Concern:

I am writing in regard to the proposed changes to the Medicare reimbursement for dual energy x-ray absorptiometry (DXA). Changes made to reimbursement will negatively impact patient access to osteoporosis screening, therefore affecting quality of life for those affected. Osteoporosis screening (DXA) assists physicians in treating patients for osteoporosis or osteopenia, providing treatment to stop the progression of bone loss.

In my clinic setting, I believe that the projected $38.00 reimbursement that is being proposed will not even cover the cost of providing this exam. Please reconsider your views on this proposed change.

Sincerely,

Jacque Sousley, R.T.R.M. (QM)
Bothwell Diagnostic Center
990 South Winchester
Sedalia, MO 65301

CMS-1512-PN-1887-Attach-1.DOC

CMS-1512-PN-1887-Attach-2.DOC

ATTACHMENT 1 TO # 1887

August, 11, 2006

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

RE: CMS-1512-PN

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Sincerely,

Jacque Sousley, R.T.R.M. (QM)
Bothwell Diagnostic Center
990 South Winchester
Sedalia, MO 65301

ATTACHMENT 2 TO H-1887

August, 11, 2006

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

RE: CMS-1512-PN

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Bothwell Diagnostic Center
990 South Winchester
Sedalia, MO 65301

Submitter : **Dr. ERIN COOKSEY** **Date: 08/18/2006**

Organization : **PRIMARY CARE ASSOCIATES, PC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1888-Attach-1.DOC

CMS-1512-PN-1888-Attach-2.DOC

CMS-1512-PN-1888-Attach-3.DOC

ATTACHMENT 1 TO #1888

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

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

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

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

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

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Erin Cooksey, M. D.
Primary Care Associates

2130 E. Greenville St. Suite 1500 Anderson, SC 29621
726 Anderson St. Belton, SC 29627
Anderson (864) 338-9819 Belton (864) 338-9819 Fax (864) 224-0281

ATTACHMENT 2 TO #1886

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

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Sincerely,

Erin Cooksey, M. D.
Primary Care Associates

ATTACHMENT 3 TO #1888

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Erin Cooksey, M. D.
Primary Care Associates

[illegible] Suite 1000 Anderson, SC 29621
[illegible] Belton, SC 29627
[illegible] Phone (864) 338-8018 Fax (864) 241-0281

Submitter : Mrs. DONNA BURROUGHS, CDE, CWCN **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1889-Attach-1.DOC

ATTACHMENT TO A 1889

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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

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

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

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

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

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

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Donna Burroughs, CDE, CWCN, APRN, BC
Primary Care Associates

2501 E. Greenville St., Suite 1600, Anderson, SC 29621
726 Anderson St., Belton, SC 29627
(864) 226-9103 Belton (864) 338-6618 Fax (864) 231-3281

Submitter : Dr. HARRY GEISBERG **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

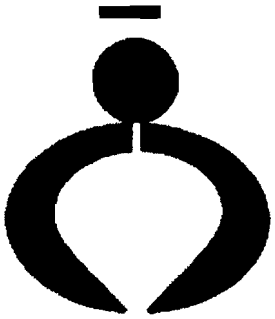
Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1890-Attach-1.DOC



Attachment to #1890

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Harry Geisberg, M. D.
Primary Care Associates

[illegible] Suite 1503 Anderson SC 29621
[illegible] Anderson St. Belton SC 29627
[illegible] Phone (864) 338-8618 Fax (864) 231-0281

Submitter : Dr. LEE HALL **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1891-Attach-1.DOC

ATTACHMENT TO #1891

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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

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

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

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

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

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Joe Martin, M. D.
Primary Care Associates

[illegible] Suite 1500 Anderson SC 29621
[illegible] Belton SC 29627
[illegible] Belton (864)338-5019 Fax (864)231-0281

Submitter : Dr. NEWMAN HARTER, JR, MD **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1892-Attach-1.DOC

ATTACHMENT TO # 1892

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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

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

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

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

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Newman W. Harter, Jr., M. D.
President, Primary Care Associates

700 E. Greenville St., Suite 1900, Anderson, SC 29621
126 Anderson St., Belton, SC 29627
(864) 225-9193 Belton (864) 338-5010 Fax (864) 231-0281

Submitter : Dr. DUANE HENK **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

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. INGRID ISAKOV **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1894-Attach-1.DOC

ATTACHMENT TO #1894

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Ingrid Isakov, M. D.
Primary Care Associates

[illegible] Greenville St. Suite 1600, Anderson, SC 29621
[illegible] Anderson St., Belton, SC 29627
[illegible] Belton (864) 338-6019 Fax (864) 231-0281

Submitter : Dr. JOE MARTIN **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

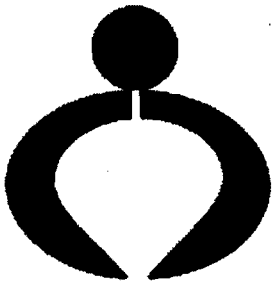
Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1895-Attach-1.DOC



ATTACHMENT TO # 1895

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Joe Martin, M. D.
President, Primary Care Associates

[illegible]

Submitter : Ms. Jerri Gee **Date:** 08/18/2006

Organization : Osteoporosis Center of Denton

Category : Other Health Care Professional

Issue Areas/Comments

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

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

Working in an Osteoporosis Center and performing bone density testing. Some think it's a quick procedure. (The patient is on the scan table 8-10 mins.) They must register first. The technician goes over a detailed questionaire pertaining to lifestyle, disease, medicine, diet, exercise & nutrition. There is discussion/education about osteoporosis prevention/diagnosis/treatment. When the scan is complete, the pt. is educated on calcium & nutrition to protect the skeleton.
This is a vital test to help protect the population as they are living longer. We need this test, and if the reduction in MC payments continue, it won't be afforable to testing centers or pts. The cost of this equipment is $80,000, and the expense to maintain and the expense of supplies is also expensive. Reduction in reimbursement will make it too costly to provide this testing at such a low rate.
A DXA scan is not like a peripheral scan. The peripheral scanner is very inexpensive, there is little cost for supplies, and the results are also very inaccurate.

Submitter : Dr. MARSHALL MEADORS III, MD **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1897-Attach-1.DOC

ATTACHMENT TO # 1897

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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

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

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

It is extremely important to realize that even though the software provides a mechanical interpretation for the scan this information is often incorrect if the physician does not properly evaluate the information. Ms. Jones was a 75-year-old woman with osteoarthritis at the lumbar spine and osteoporotic values at the neck of the bilateral hips. Without careful history and interpretation a falsely elevated total spine would be reported as normal and the total hips would be reported as osteopenic. When one couples her maternal history of hip fracture with the values at the neck region of her hips, the patient required treatment for osteoporosis.

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Marshall Meadors, M. D.
Primary Care Associates

2001 E. Greenville St. Suite 1600, Anderson, SC 29621
125 Anderson St., Belton, SC 29627
Anderson (864) 226-0145 Belton (864) 338-6514 Fax (864) 231-0281

Submitter : **Dr. REBECCA NORRIS** **Date: 08/18/2006**

Organization : **PRIMARY CARE ASSOCIATES, PC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1898-Attach-1.DOC

#1898

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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

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

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

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

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

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

It is extremely important to realize that even though the software provides a mechanical interpretation for the scan this information is often incorrect if the physician does not properly evaluate the information. Ms. Jones was a 75-year-old woman with osteoarthritis at the lumbar spine and osteoporotic values at the neck of the bilateral hips. Without careful history and interpretation a falsely elevated total spine would be reported as normal and the total hips would be reported as osteopenic. When one couples her maternal history of hip fracture with the values at the neck region of her hips, the patient required treatment for osteoporosis.

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Rebecca Norris, M. D.
Primary Care Associates

[illegible] Stevens St. Suite 1600 Anderson SC 29621
[illegible] Anderson St. Belton SC 29627
864-[illegible] Belton (864) 336-5[illegible] Fax (864) 231-0281

Submitter : Ms. PATTY YOUNG, APRN, BC **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

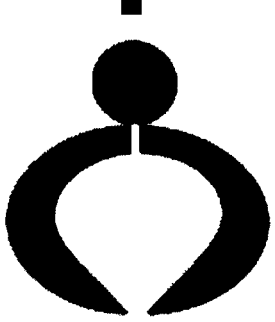
Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1899-Attach-1.DOC

#1899



PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Patty Young, APRN, BC
Primary Care Associates

2000 E. Greenville St. Suite 1600, Anderson, SC 29621
726 Emerson St. Belton, SC 29627
(864) 760-6161 Belton (864) 338-8010 Fax (864) 221-0261

Submitter : Ms. ANGELA REEVES, APRN, BC **Date:** 08/18/2006

Organization : PRIMARY CARE ASSOCIATES, PC

Category : Health Care Professional or Association

Issue Areas/Comments

Other Issues

Other Issues

PROPOSED REDUCTION OF DEXA REIMBURSEMENT

CMS-1512-PN-1900-Attach-1.DOC

#1900

PRIMARY CARE ASSOCIATES, P. C.

August 17, 2006

Re: CMS-1512-PN

Dear Dr. McClellan:

I am a family practice doctor practicing in Anderson, South Carolina providing care to numerous Medicare recipients. Many of our elderly patients suffer from osteoporosis or osteopenia.

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

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

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

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

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

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

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

Your careful review of this urgent situation is greatly appreciated.

Sincerely,

Angela Reeves, APRN, BC
Primary Care Associates

Anne E. Greenville St. Suite 1600 Anderson, SC 29621
320 Anderson St. Belton, SC 29627
Belton (864) 338 6019 Fax (864) 221 0281

Submitter : Melanie B Ness **Date:** 08/18/2006

Organization : Melanie B Ness

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am a licensed clinical social worker in Virginia and the District of Columbia. I am writing to comment on the proposed CMS cuts to reimbursement as proposed in CMS-1512-PN. LCSWs provide 41% of the nation's mental health services. I am concerned about my ability to provide psychotherapy to Medicare enrollees. I frankly would not be able to cover my business expenses. Also, I see patients mostly under the CPT code 90806, as do psychologists. They, however, are reimbursed at a 25 % higher rate than clinical social workers. That is highly unfair. So, I would appreciate your withdrawing the current proposed cuts in reimbursement to LCSW providers of psychotherapy, and as well, consider changing the inequitable reimbursement system that currently exists, and implement equal pay for equal codes. Otherwise, I am afraid that far fewer enrolees with be able to obtain mental health treatment.

Submitter : Ms. Linda Nash **Date:** 08/18/2006

Organization : Manatee Surgical Center, Inc.

Category : Ambulatory Surgical Center

Issue Areas/Comments

Practice Expense

Practice Expense

See attached

CMS-1512-PN-1902-Attach-1.DOC

#1902

Manatee Surgical Center

601 Manatee Avenue West
Bradenton, FL 34205
941-745-2727

August 16, 2006

Mark McClellan, M.D., PhD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Dear Dr. McClellan:

In the June 29, 2006 Federal Register, CMS proposed a new practice expense methodology, as well as changes in work values stemming from the recently conducted Five Year Review. Due to these changes, Medicare payments to Anesthesiologists and Anesthesia personnel would be cut 10% over the next four years. These cuts to anesthesiologists and other specialists are meant to supplement the overhead costs increases for a handful of specialties. Further, these cuts are in addition to the Sustainable Growth Rate (SGR) formula cuts of 4.7% expected January 1, 2007. I am concerned because these cuts are proposed without precedent or justification and would have wide ranging effects on hospitals and patients' access to healthcare. Please consider the following

> These cuts are severe and unprecedented. In 1997, and again in 2002, CMS Part B payment formula changes resulted in adjusted payment work values of less than one percent each. Now, CMS is proposing a 10% cut by 2010.
>
> Anesthesia is already undervalued by Medicare relative to market rates. While Medicare pays 80% of private market rates for most Part B services, Medicare now pays only **37%** for anesthesia services.
>
> Many services whose reimbursements have been affected by the Five Year Review have been subjected to extensive study and examination. However, it appears no such examination has been made of the effects that a 10% cut in anesthesia reimbursement would have on patients' access to the healthcare system.

The end result of the above actions would place reimbursement for anesthesia services at the same rate as in 1991. The practice of anesthesia has become much safer since 1991 because of advancements in equipment and medications as well as superior training of anesthesia providers. If these cuts are allowed, it will be difficult if not impossible to afford new technologies and pharmacologic advancements. It will be difficult to even sustain our current equipment and overhead expenses. In addition, experienced anesthesia providers and mentors will invariably leave the workforce or take on a greatly reduced role in patient care. This would result in a critical manpower shortage just as our population is getting older and requiring more care. The practice of

anesthesiology may even "regress", and become less safe than it is today by having to revert to older technologies and outdated equipment in the hands of less experienced practitioners.

The data that the CMS is using to calculate overhead expenses is outdated and significantly underestimates actual expenses. The CMS should gather new data on anesthesia practice expenses and replace to decade old data it is currently using. The American Society of Anesthesiology (ASA) and AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. This much needed survey should be launched immediately to improve accuracy of practice expense data for all specialties.

For these reasons, I respectfully request CMS suspend its proposal of Medicare cuts in anesthesia reimbursement, in order to allow for a comprehensive review of the impacts such cuts would have on anesthesia technology, manpower, and patient safety.

Sincerely,

Linda M. Nash, MBA, CASC, LHRM
Administrator/Risk Manager
Manatee Surgical Center, Inc.

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

Organization : Methodist Physicians Clinic

Category : Physician

Issue Areas/Comments

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

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

Your planned reduction of practice expense reimbursement for dxa tests for osteoporosis is based on faulty methodology. Current equipment uses fan beam, not pencil beam, technology. If reimbursement were cut below economic resource costs, screening rates would fall. If screening rates fell, fewer diagnosis and treatment of osteoporosis would occur, resulting in greater fractures and costs to the system.

Submitter : Mr. kevin roerden **Date:** 08/18/2006

Organization : musc

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

This cut will effect a negative climate for the practicing CRNA's of our state of SC and diminish the availability of anesthesia sevices to the rural communities which already are struggling to provide healthcare to our nations children and elderly.

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

Organization : Dori Aronson

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am a Licensed Clinical Social Worker in Maryland and the District of Columbia and a member of the Clinical Social Work Association. I am writing to comment on the proposed CMS cuts to reimbursement rates as proposed in CMS-1512-PN. Clinical social workers, who provide 41% of the nation s mental health services (CSWF, 2005), are often the only mental health clinicians available to our nation s elderly. I am concerned about the impact these cuts will have on my ability to continue to provide services to Medicare enrollees. While I see most Medicare enrollees under Current Procedural Terminology (CPT) Code 90806, I am reimbursed at a level that is 25% lower than the rate for psychologists for the same codes. This has always seemed unfair, since the same codes mean the same kinds of services are being provided. However, lowering the reimbursement rates further, as the 14% proposed cuts would, would make it impossible for me to cover my business expenses and, therefore, would make it difficult to continue serving the Medicare enrollees I currently treat.

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

Submitter : Mr. Aon Barrett **Date:** 08/18/2006

Organization : 360 Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

Dear Medicare Administrator:

My name is Aon Barrett, and I have been a physical therapist for 5 years. I work at 360 Physical Therapy & Aquatic Center in Tempe, Arizona. We are a private, therapist owned outpatient center, and we only hire physical therapists to treat patients, which ensures the highest quality of care to the community we serve.

The recent policy proposal to cut Medicare reimbursement raises serious concerns for me. The previous cap on therapy services has already severely limited the ability to provide adequate care to many individuals. By further limiting reimbursement, the patients will ultimately be the losers. It seems as though we have forgotten to whom our ultimate responsibility is; the patient in need of our services.

The Medicare coding policy already ensures that physical therapists are held accountable for the services they render to clients. For example, a facility cannot bill for services provided by non licensed therapist, and we must bill the group code when treatment overlaps with another client, and then there is a cap placed on Allied Health services that took effect early this year. Further limited services will not only directly affect a facility economically due to possible lay offs, but it may also reduce beneficial services to clients, which will have a significant deficit to their functional outcome.

With so many baby-boomers living longer and healthier lives, the need for physical therapy professionals and services will rise, and reducing coverage for services would do a great disservice to our healthcare system, as many of our clients will not receive optimal services for their specific ailments. With many insurance premiums and co-pays being high already, most seniors rely on Medicare to cover most of their healthcare needs.

Physical therapists spend a lot of time with each client they treat, as compared to other healthcare providers. Reducing services through cost cutting will in effect devalue our services, and will result in a negative outcome for many of our clients.

If changes such as the one currently suggested is absolutely necessary, it would be more practical to implement such policies over a period of time. An example would be to do so at a pace of 1% over a ten year period of time.

I thank you very much for considering the comments I made above.

Sincerely, Aon Barrett, PT #6264

Submitter : Mrs. renee quiles **Date:** 08/18/2006

Organization : meridian bone density specialists

Category : Other Technician

Issue Areas/Comments

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

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

I am writing on behalf of my organization Meridian Bone Density . I have been informed of the proposed reduction in fees regarding DEXA scans technical component. I have two locations in the state of Washington that does a high volume of Medicare patients. As an outpatient facility I try to make my clinics accessable to the elderly population by flexiable hours and saturday appointments in case they need transportation. The two Dexa units I purchased are Hologic and cost $86,000 a piece. The technologists that run the units are paid over $35 and hour. We are capapble of providing this exam in 45 minutes. The overhead that it takes to provide this service is extremely high when you include rent, phone, transcription, billing services, malpractice insurance, and insurance on the machines. The present rates are significantly lower than other insurance companies for the 76075TC and I knew that when I became a provider for Medicare. The present rate in which we are reimbursed is a fair value for all that is involved in performing DEXAS. Years ago the units used to measure bone denstiy were less expensive and the technology consisted of pencil beams. Todays units, of which I use, are a fan beam technology. This form of xray is more accurate and the precision superb for diagnosing osteoporosis. I have been an xray technologist for 20 years and my passion is in the aging population. I cannot begin to tell you how many fractured hips and spines I have had to image and if I can help one person have a quality aging life than I feel I have done my job. My comments are not because of money, God has always provided for me. It is about offering a service to the Medicare poplation that deserve a quality exam that is offered in a private atmosphere, at a pace that they are comfortable with, and absent of other sick patients of which you find in radiology departments. Having performed over 4000 Dexa scans in the past 5 years, I know how much of a negative impact this will have on post menopusal women as well as high risk men. I can only hope that you and your staff would reconsider such drastic reductions in the payment fee so that these services can still be performed and meet the overhead it requires to perform DEXA scans. Thank you for your time .

Sincerely Renee Quiles (RTRMD)

Submitter : **Ms. Ilene Gaffin** **Date: 08/18/2006**

Organization : **Private Practice**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

Iam writing to oppose the upcoming reduction in medicare reimbursement for clinical social workers, beginning January 2007. Social workers are some of the most cost effective providers of counseling. Such a reduction will reduce the numbers of social workers willing to see clients under Medicare. Further, it is also not equitable to increase the reimbursement for some provider functions and reduce those of others. This needs to be considered further. I urge you to do so.

Ilene Gaffin, LCSW, New York State

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

August 18, 2006

Dear Dr. McClellan:

We are Family Practice Associates, CHTD. practicing in Kansas City, KS and Shawnee, Ks.

I am gravely concerned about the proposed drastic cuts in payment for dual energy X-ray absorptiometry (DXA; CPT code 70675) and vertebral fracture assessment (VFA; CPT code 76077). These cuts have been proposed as part of a new five-year review of the Medicare Physician Fee Schedule.

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

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

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

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

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

We have patient X that has osteoporosis and he has stated that he would not go to a hospital to have this test done. He already has compression fractures in his back and without the treatment and testing done in the office he could have more fractures, including a hip fracture if he falls. Without our office testing he would not get the treatment needed in prevention.

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

Thank You,

Family Practice Associates, CHTD.

Submitter : Dr. Herbert Ladley **Date:** 08/18/2006

Organization : Cardiovascular Associates, P.C.

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

see attached

CMS-1512-PN-1910-Attach-1.PDF

#1910

Cardiovascular Associates, PC
www.theheartcenter.net

KINGSPORT
The Heart Center
2050 Meadowview Parkway
Kingsport, TN 37660
Phone 423.230.5000 or
800.322.4124
FAX 423.230.5010

BRISTOL
Bristol Regional Medical Center
One Medical Park Blvd., Ste. 458-W
Bristol, TN 37620
Phone 423.844.4975 or
866.741.6129
FAX 423.844.4987

ABINGDON
Tanner-White Medical Bldg.
273 White Street
Abingdon, VA 24210
Phone 276.739.0067
FAX 276.739.0069

NORTON
616 Park Avenue, NW
First Floor
Norton, VA 24273

August 18, 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 Associates, P.C. and our 29 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.

We are the largest private practice cardiology group in Northeastern Tennessee having had over 90,000 patient encounters in 2005 and offering state-of-the-art services including heart catheterizations, echocardiograms, nuclear scans, CTs, and MRs.

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,

Herbert Ladley, M.D., F.A.C.C., F.S.C.A.I.
President