Submitter : **Pam Michael, MBA, RD** **Date: 08/18/2006**

Organization : **The American Dietetic Association**

Category : **Dietitian/Nutritionist**

Issue Areas/Comments

Discussion of comments-HCPAC Codes

Discussion of comments-HCPAC Codes

see attachment from the American Dietetic Association

GENERAL

GENERAL

see attachment from the American Dietetic Association

Practice Expense

Practice Expense

see attachment from the American Dietetic Association

CMS-1512-PN-1911-Attach-1.DOC

#1911

American Dietetic Association
www.eatright.org | *Your link to nutrition and health℠*

Headquarters
120 South Riverside Plaza, Suite 2000
Chicago, Illinois 60606-6995
312/899-0040 800/877-1600

Washington, D.C. Office
1120 Connecticut Avenue N.W., Suite 480
Washington, DC 20036-3989
202/775-8277 800/877-0877

August 18, 2006

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

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

Dear Dr. McClellan:

The American Dietetic Association (ADA) appreciates this opportunity to present our comments on the CMS-1512-PN, *Medicare Program: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology.* We urge you to consider this information as you refine the Final Rule for Calendar Year (CY) 2007.

The ADA represents approximately 65,000 food and nutrition professionals working to improve the nutritional status of Americans. As primary prevention, strong evidence indicates that nutrition helps promote health and functionality and affects each individual's quality of life. As secondary and tertiary prevention, medical nutrition therapy (MNT) is a cost-effective disease management strategy that lessens chronic disease risk, and which slows disease progression and reduces symptoms. Medicare Part B covers MNT provided by registered dietitians (RDs) for diabetes and chronic renal disease.

The ADA understands the August proposed rule, *Revisions to Payment Policies Under the Physician Fee schedule for Calendar Year 2007 and Other Changes to Payment Under Part B* (CMS-1321-P), will further describe proposed RVU adjustments to the medical nutrition therapy (MNT) CPT codes, therefore our comments focus on the practice expense methodology outlined in CMS-1512-PN.

These comments represent the position of ADA. Individual ADA members may also submit comments expressing their own views to CMS on the proposed PE methodology

and revisions to the Medicare physician fee schedule. In addition to the comments that we present on behalf of the professional association, we recommend your consideration of these individual comments from other RDs.

Five-Year Review: Discussion of Comments- HCPAC Codes
CMS indicated that ADA "submitted five CPT and HCPCS codes related to medical nutrition therapy services that were referred to the CPT Editorial Panel." ADA made this decision within the five-year review process, and as an effort to correct what we believe is CMS' erroneous interpretation of the MNT statute where work values were not assigned to the MNT codes.

Practice Expense:
While CMS believes the proposed bottom up practice expense (PE) methodology will be more transparent, ADA believes further explanation is needed to understand data used in the calculations for MNT codes. CMS has not indicated the specific MNT PE values used in the recent calculations for the new methodology, however previous PE MNT inputs are as follows:

CMS PE MNT inputs

2006 NPRM labor cost inputs (excerpt)

HCPCS	Source	CPEP	Staff Type	Description	Rate	Pre-Time NF	Intra-Time NF	Post-Time NF	Pre-Time F	Intra-Time F	Post-Time F	Valued NF	Valued F
97802	HCPAC	RUC	L043B	Registered Dietician	0.43	3	15	7	0	0	0	Y	Y
97803	HCPAC	RUC	L043B	Registered Dietician	0.43	3	15	4	0	0	0	Y	Y
97804	HCPAC	RUC	L043B	Registered Dietician	0.43	1	7	1	0	0	0	Y	Y

Source: 42 CFR Parts 405, 410, 411, 413, 414, 426 [CMS-1502-P]. Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006-Proposed Rule

Corrections to MNT PE input values
CMS has used incorrect PE data in its PE calculations for the MNT codes, particularly in the MNT PE pre- and post-service times. Certain pre and post-service activities are missing from the cost inputs originally implemented when the MNT codes were established. For example, pre-service activities such as provide pre-service education regarding session appointment, office location, patient completion of self assessment forms; and other clinical activity such as review chart; prep of room, equipment; and display set-up such as food models and computer equipment. ADA's expert PE panel estimates these pre-service times as 6 minutes (versus the 3 minutes noted in the above table). The MNT post-service time of 7 minutes (from CMS table above) also omits activities completed by the RD; documentation and recording outcomes, cleaning

Practice Expense, continued:
the room, storing equipment and supplies, and conducting phone calls. ADA's PE expert panel indicates post service time for the MNT individual codes as 8 minutes for 97802 and 97803. The ADA PE expert panel revised pre and post times are based on standard times used by the AMA Practice Expense Review Committee (PERC). The ADA recommended PE times for all MNT codes are displayed below.

Revised PE times for MNT codes

MNT Code	Pre-time	Intra-time	Post-time
97802 (each15 min)	6	15	8
97803 (each 15 min)	6	15	8
97804 (each 30 min)*	2	8	2
G0270 (each 15 min)	6	15	8
G0271 (each 30 min)*	2	8	2

*Note: values adjusted for typical group size of 4

Apply the Same MNT PE Inputs Across the MNT Codes
As shown above, ADA believes the same PE inputs for pre, intra, and post-service times should be applied to all the MNT codes for individual service (97802, 97803 and G0270) and also the group MNT codes (97804 and G0271). Since the codes are time-based, the PE will vary depending on the units of code required to provide the initial or follow up MNT service. ADA asks CMS to adjust the inputs for 97803 and G0270, and then 97804 and G0271 accordingly.

Elimination of the NPWP
ADA agrees with CMS' decision to eliminate the non-physician work pool, and looks forward to assisting CMS as the agency establishes work values for the MNT codes.

Adoption of a multi-specialty PE survey
ADA strongly believes a new survey process is necessary in order to verify PE data used in CMS calculations, to replace older SMS survey data, and make data available where it is currently missing. By allowing all groups -- physician and non-physician societies -- to gather PE data in a systematic, consistent approach, CMS can create a data base that more accurately represents current PE for the various healthcare groups. ADA supports this initiative and will participate in AMA and CMS activities to draft and field test a new PE survey.

Budget neutrality
Based on the Omnibus Budget Reconciliation Act of 1989, ADA understands CMS requirements to apply an adjustment factor to the Medicare physician fee schedule in order to maintain budget neutrality. Instead of the agency's use of a new "work

Budget neutrality, continued
adjuster" to ensure budget neutrality as outlined in CM-1512-PN, ADA asks the agency to apply the adjustment to the Medicare conversion factor for the 2007 Medicare physician fee schedule. Using the Medicare conversion factor for next year's physician fee schedule is consistent with previous agency actions since CMS has used this adjuster in fee schedules since 1998. Application of the adjustment to the conversion factor is preferable because it has less impact on other payers who use the Medicare RVUs, it is more transparent than other adjusters, and it links the adjustment to budget neutrality and monetary reasons versus adjustments in the codes' work values.

ADA looks forward to meeting with CMS to further discuss the PE methodology and proposed work values for the MNT codes that will be reflected in the CY 2007 final rule. Please do not hesitate to call me (312-899-4747) with any questions or requests for additional information.

Sincerely,
Pam Michael, MBA, RD
Director, Nutrition Services Coverage Team
American Dietetic Association

Submitter : Mr. Andrew Einhorn **Date:** 08/18/2006

Organization : Los Alamitos Ortho and Sports PT

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

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

Subject: Medicare Program; Five-Year review of Work Relative Value Units under the physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

I am a practicing Physical Therapist for some 26-years. Physical Therapists spend considerable time in face-to-face consultation and treatment with patients, yet their services are being reduced in value. I would recommend that severe Medicare payment cuts for Physical Therapists are not the way to create better access to valuable health care services in 2007.

Under current law, the SGR formula is projected to trigger a 4.6% cut in payments in 2007. Similar cuts are forecasted to continue for the foreseeable future, totaling 37% by 2015. It is unreasonable to propose policies that pile cuts on top of cuts.

I would like to thank the administrator for his consideration of my comments. If you have any questions, please contact me at the address below.

Sincerely,

Andrew Einhorn, PT
4226 Katella Ave
Los Alamitos, CA 90720
562.431.6004

Submitter : Mrs. Michelle Salois **Date:** 08/18/2006

Organization : Multicare

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

I am a Bone Densitometer Technician working at a Multi-specialty Clinic in Covington, WA.

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.

The patients I provide service for NEED DXA access. This regulation would only disregard the healthcare of all patients.

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,

Michelle Salois, CDT, MA
25851 196th Ave SE
Covington, WA 98042

Submitter : Mr. Javier Berezdivin **Date:** 08/18/2006

Organization : Mr. Javier Berezdivin

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

In genereal, medicaid payments to providers are very low. I would not recommend any further reductions in payments to your providers. Americans health should be an important priority to the government, and the only way of attracting competent providers is to make their work wothwhile. Please,do not lower your payments to your doctors.

Submitter : **Dr. Michael Sayers** **Date: 08/18/2006**

Organization : **Arthritis Associates of Colorado Springs**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1915-Attach-1.DOC

#1915

RTHRITIS
SSOCIATES
STEOPOROSIS
of Colorado Springs

Michael Sayers, D.O. Martha D'Ambrosio, M.D.
Douglas Lain, M.D. Michael Baker, M.D.

To Whom It May Concern:

I am a practicing rheumatologist in Colorado Springs providing care to many osteoporotic and osteopenic patients. I am very concerned about the proposed changes to the Medicare Physician fee Schedule.

This change would result in a profound reduction in reimbursement for our consultative service. The assumption regarding equipment cost of DXA is calculated utilizing the cost information using pencil-beam technology, but our system (as do most good centers) use a fan beam technology. This allows for an underestimate of the actual cost. Pencil beam technology may be employed in screening units but are generally not used for diagnostic and longitudinal follow-up of patients.

I believe this will negatively impact our patient population. I hope you will seriously reconsider changes which I think will result in fewer people being screened and properly diagnosed, more patients treated empirically with expensive medications having potential risks, and patients being treated that are not adequately monitored over time.

Thank you, for your consideration in this matter.

Respectfully,

Michael E. Sayers DO, FACP

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

Organization : Another choice, another chance

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Regarding The Centers for Medicare and Medicaid Services notice of the Components of the Medicare Physician Fee Schedule and the Practice Expense values. As a clinical social worker practicing in the field of child welfare for ten years the 14 percent cut in reimbursement will greatly impact the service I provide for children who have experienced child abuse, have emotional and behavioral issues, and are at risk for involvement in the Juvenile Justice Department. In a field that is understaffed with high caseloads for youth and families that are in need. The impact on the social work profession is that the children in this specialty will be at risk for be underserved and at risk for further child maltreatment, not receiving interventions for severe emotional and behavioral problems, and possibly have greater involvement in the Juvenile Justice system which could involve a higher degree of youth committing crime or needing protective custody. I am contacting you to request CMS to reduce work values for clinical social workers effective January 1, 2007. I am requesting CMS to withdraw the propsoed increase in evaluation and management codes until the have the funds to increase reimbursement for all Medicare provider. Furthermore, I am requesting CMS not to approve the proposed bottom up formula to calculate practice expense. Please select a formula that does not created a negative impact for clinical social workers who have very little practice expense as providers. Thank you.

Submitter : Mr. Chris Caggiano **Date:** 08/18/2006

Organization : Cannon Family Medicine

Category : Physician Assistant

Issue Areas/Comments

GENERAL

GENERAL

Please do not decrease the "Physician Fee" for CPT 76075. It already takes a technician a fair amount of time to set up, calibrate, take down, and maintain the machine. In addition, the time alloted to perform the DXA examination properly would not be justified by the proposed reduced "Physician Fee" and would force many health care facilities to abandon this procedure. This would have a great impact on the health of many patients and in the long run result in undiagnosed Osteoporosis and therefore an increase in fracture related morbidity and eventual mortality. For example, when an elderly person suffers a hip fracture, he/she often "dwindles" slowly with multiple visits to various health care providers and orthopedic physicians / surgeons. Also as a note, many patients are not convinced to take supplemental calcium and Fosamax (and other related medictions) without first seeing evidenced based results from the DXA.

Submitter : Ms. Constance Ridgway **Date:** 08/18/2006

Organization : Clinical Social Work Association

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in Virginia and Washington DC. 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, are often the only mental health clinicians available in a given locality to serve our nation's elderly. These cuts would severely limit or curtail 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, even though the same codes mean the same kinds of services are being provided. Lowering the reimbursement rates further, as the 14% proposed cuts would, would make it impossible for me to cover my business expenses and, therefore, would make it difficult to continue serving the Medicare enrollees I currently treat.

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

Submitter : **Dr. Andrew Tatom** **Date: 08/18/2006**

Organization : **Rehabilitation associates of central virginia**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

My name is Dr. Andrew Tatom and I have been a Physical Therapist for 24 years. I have been practicing in Virginia in an out patient ortho setting with aprox 25% of my load being medicare. I would like to comment on the June 29 proposed notice that proposes revisions to the RVU's and how they are caculated under the physicians fee schedule.
The SGR will decerase payments by almost 5% by 2007. Similar cuts are projected to decerase reimbursement by almost 40% by 2015. Cutting payment this low would make it improable that I could continue to care for medicare patients.
PT's can not bill under the E/M codes. So even with higher reimbursement for these codes It will not help the PTs of set the loss taken in other areas.
With loss of providers because of poor reimbursement the consumer will suffer for loss of acces for needed services.
I believe a 4 year transition would alow patients to have acces to the care they need.
Thank you for your concideration.
Dr. Andrew Tatom

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

Organization : Sugarloaf Counseling

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

"I am a Licensed Clinical Social Worker in MARYLAND. 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, 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. Thank you.

Submitter : Mr. John Hartline **Date:** 08/18/2006

Organization : Soka Services

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

per social work: To whom it may concern. We provide a vital service to many who can not physically function and rely upon our assistance.With all due respect, we can barely afford to provide our services at this time. A cut in pay would send many of us to other areas, causing a tragic decrease of help for the truly needy. Thank you for kindly considering this sincere input. John Hartline LMSW

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

Organization : Susan White

Category : Individual

Issue Areas/Comments

Practice Expense

Practice Expense

Our family is financially supported by a social worker who sees Medicare patients. Practice expenses are increasing - electricity at the office has doubled in the past year! - and we cannot afford cuts in reimbusement. Help keep our family financially solvent, please, and do not cut Medicare reimbursements to hard-working socialworkers. Thank you.

Submitter : Ms. joanna Chaleff **Date:** 08/18/2006

Organization : Ms. joanna Chaleff

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I urge you not to allow a 14% cut in reimbursement rates for Social Workers who are medicare providers. Most of the mental health providers who are still accepting medicare patients are Social Workers. If you allow any further reductions in reimbursement rates, you will force us to turn away medicare patients in order to survive financially. I also urge that you come up with the funds to increase reimbursemnt for all Medicare providers without reducing work values for clinical social workers in Jan., 2007. Please withdraw the proposed increase in evaluation and management fees, and finally, do not approve the proposed 'bottom up' formula for calcuating practice expenses; it discriminates against Social Workers whose practice expenses are less as providers.

Thank you,

Joanna S. Chaleff, LCSW

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

I'm a physical therapist assistant working in a very busy outpatient physical therapy practice in western Washington state. I have been with my present employer for almost 4 years. Previously I worked in home health for 8 years in Colorado and Utah. I have also worked in rehab and long term care during my home health employment. I've seen several changes in Medicare reimbursement, gone through reviews, and seen lay offs and staff cut backs. Therapists come and go and can always find a job elsewhere if their position is changed or eliminated. Those who suffer the most during these transitions are the patients. The purpose of this comment is to urge CMS to ensure that Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007.

In skilled nursing facilitities and rehab, much needed hours of care are decreased as compensation becomes limited. This results in inadequate training for transition to home or independence in their facilities. This results in a need for more nursing care, which is also sadly limited. In home health, patients see much needed help and relief less often, resulting in longer recovery periods. In an outpatient setting patients are reduced to one or two visits to a therapist a week to address typically ROM and strengthening intervention which should be addressed 3-4x/week for timely recovery and return to work or sports.

As our services are cut in any setting, people are less able to wean themselves from outside financial assistance, as they have agonizing and prolonged rehabilitation as they lack guidance and hands on care.

I recommend that CMS transition the changes to the work relative value units over a four year period to ensure that patients continue to have access to valuable health care services.

Thank you for your consideration.

Sincerely, Jill Armijo, PTA

Submitter : Dr. Irwin Weinstein **Date:** 08/18/2006

Organization : Orlando Heart Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1925-Attach-1.DOC

#1925

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 the Orlando Heart Center and our 22 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.

Our practice at 60 West Gore Street in downtown Orlando was established in 1968 and provides the full spectrum of consultative, interventional, electrophysiological and noninvasive cardiovascular services to the metro area. We participate in one outpatient catheterization laboratory, the Orlando Cardiovascular Center, which was established as an ITDF and includes two other cardiologists, each from a different group. The Orlando Cardiovascular Center performs about 900 to 1000 diagnostic cases annually.

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"). 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, 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,

Irwin R. Weinstein M.D., F.A.C.C.

President, Orlando Heart Center

Medical Director, Orlando Cardiovascular Center

Submitter : Dr. Guy Orangio **Date:** 08/18/2006

Organization : American Society of Colon and Rectal Surgeons

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1926-Attach-1.PDF

#1926

The American Society of Colon and Rectal Surgeons

85 West Algonquin Rd., Suite 550, Arlington Heights, IL 60005
(847) 290-9184 Fax: (847) 290-9203 Website: http://www.fascrs.org/ E-Mail: ascrs@fascrs.org

August 20, 2006

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

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

Submitted electronically at http://www.cms.hhs.gov/eRulemaking

Dear Dr. McClellan:

On behalf of the members of the American Society of Colon and Rectal Surgeons (ASCRS), the following comments are submitted in response to the Proposed Rule published in the *Federal Register* on August 29, 2006. We appreciate the participation of CMS staff during the review of physician work and for accepting many of the RUC recommendations. We will be commenting on both general issues and code specific issues for our own procedures and for other codes where CMS disagreed with some basic RUC approved principles that we believe are extremely important. We are also offering comments on some proposed changes to the methodologies for practice expense calculations and for budget neutrality. We have organized our comments into sections as requested in the Proposed Rule.

General Comments

We join the American College of Surgeons, the American Medical Association, the Society of Thoracic Surgeons, the American Academy of Orthopaedic Surgery, and essentially all of medicine in being disappointed by CMS' treatment of data collected from the National Surgical Quality Improvement Program (NSQIP) database; the Society of Thoracic Surgeons (STS) National Database, and CMSs own national DRG database, and we urge CMS to reconsider its decision to ignore the value of information collected from these databases, unless CMS can provide objective comments and rationale as to why CMS has decided that a survey of 30 (or fewer) respondents is more representative, accurate, and meaningful than independently collected and audited data sources. In general, we believe CMS' treatment of massive data collection efforts does not support the regulatory requirements to maintain a resource-based relative value scale that is an accurate representation of the work performed by physicians.

Clearly, the average (or median) of hundreds or thousands of cases will approach a national distribution better than 30 willing survey volunteers. We continue to make the point that large, audited databases are more representative than is data obtained from a 30-person survey.

We strongly encourage CMS join all of medicine in adopting a policy to use the best data possible when valuing the work of physicians. Despite the AMA/Specialty Society RVS Update Committee's (RUC) efforts, the decisions presented in the Notice of Proposed Rulemaking do not reflect this principle of always searching for the most accurate or objective data. In addition, many of CMS' decisions have produced a plethora of rank order anomalies that create inaccurate and bizarre situations that will have to be corrected during the next five-year review period. If left uncorrected, these anomalies will also create problems in the selection of reference codes over the next five years. For these reasons, we urge CMS to reconsider the peer-reviewed recommendations of the RUC that utilize these large databases in various ways (often in conjunction with surveys) and accept the RUC recommendations in the final rule. Alternative, CMS should provide a clinical rationale, as required by CMS and the RUC for the past 15 years, for why a specific work RVU chosen by the Agency is more correct or appropriate than one derived from large numbers of objectively collected encounters and extensive deliberation by all of medicine.

Discussion of Comments – Evaluation and Management Services

We are concerned about the dramatic increase in several Evaluation and Management (E/M) codes, in particular 99213. We do not believe that compelling evidence was presented to increase the work RVU of this code by more than 37 percent. Furthermore, this increase creates a host of rank order anomalies for codes with a global period that include E/M services that will create an avalanche of requests for increases during the next five years and in the next five-year review. We urge CMS to correct the anomalies within and between the E/M code families before the final rule is published in November.

CMS acknowledges that the RUC's recommendations were based on the principle that incorrect assumptions were made when these E/M codes were originally valued. While this may be true, these false assumptions were corrected in the first five-year review and 35 E/M codes, including 99213, were increased by upwards of 16 percent to compensate for these issues. It is not equitable to allow these codes to be brought forward again for revaluation based upon incorrect assumptions that were already corrected over ten years ago and for which a second five-year review was undertaken with no comment from the specialties who primarily use these codes. The primary compelling evidence that was discussed and accepted by the RUC was that "all codes within a family should not have the same intensity." Therefore, we believe that the adjustments should have been made within and between families to correct this and not to increase almost all E/M codes.

More importantly than the intensity issue, we strongly believe physicians have already been compensated for the increased work of providing E/M services by billing longer and more intense visits (ie, higher levels). CMS and the RUC have been shown concrete data that since 1994, despite an increased number of total beneficiaries, the number of 99212 office visits has

With regard to catheterizations: the proposed change in PE RVUs would decrease payments for CPT 93510 TC by more than 53 percent. Payment for two related codes—93555 TC and 93556 TC - also would decrease significantly. Under the Medicare Physician Fee Schedule (PFS), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate 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 cost approach is 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 comply with the statutory requirement to match resources to payments. After reviewing the proposed methodology, including the 19-step calculation, CAA and other organizations have identified several flaws that result in an underestimation of the resources needed to provide the technical component of cardiac catheterizations:

Direct Costs

The estimate of direct costs is critical 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 are to reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. However, the direct costs submitted to CMS by the RUC do not reflect estimates of additional labor, supply and equipment costs that were submitted by the Society for Cardiovascular Angiography and Interventions (SCAI). As a result, the RUC-determined cost estimate is about half of what would result if all of the data were included. Including these additional costs, 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, 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. In addition, there are further improvements that can be made in the manner by which the indirect costs are estimated.

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 the direct costs at the procedure level and the indirect costs at the practice level.

Summary of Jacksonville Heart Center comments on the Proposed Rule re: Practice Expense changes

Our practice believes that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization and other TC-heavy procedures, and that 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 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. Should CMS adopt its proposed rule on practice expenses as it is currently written, the unintended consequences would be significant:

1. Insufficient reimbursement would force outpatient cath labs to close. Medicare patients would be directed back to the inpatient setting for cath services. This runs counter to CMS' long-term goal of providing care in the outpatient setting whenever clinically appropriate.
2. Hospitals are not prepared to handle a large influx of catheterization cases, and the resulting wait times may very well endanger Medicare beneficiaries who need these critical cardiac services.
3. Medicare beneficiaries' out-of-pocket costs would increase, as hospital co-pays are up to 40 percent higher than those in the outpatient setting.
4. Medicare patients also would be inconvenienced by longer drive times and increased waiting periods for test results.
5. Driving Medicare patients back into the hospital setting for imaging tests also would include increased costs to the Medicare program as a whole.
6. Physician practices are small businesses, employing hundreds of thousands of people and providing valuable services to the Medicare population. The physician sector must have stable reimbursement patterns that keep pace with the increasing cost of providing care.

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. We are concerned that the problems with the catheterization codes as outlined above may extend to other CPT codes with significant TC costs as well, since the inadequate funding of catheterization codes illustrates that the data and formula used to calculate practice expense components is incomplete and inaccurate. As a result, Jacksonville Heart Center requests that CMS delay implementation of the practice expense changes for one year. During this time period, CMS, RUC, SCAI, CAA and other interested parties will be able to complete a thorough assessment of the direct and indirect cost data and the methodology currently under consideration to ensure that they are accurate and complete. CAA will be collaborating with our members and other organizations to develop improved estimates

of direct costs and to offer additional comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007.

Comments regarding Proposed Notice re: Five-Year Review of Work Relative Value Units under the Physician Fee Schedule

Jacksonville Heart Center understands that CMS is required by statute to offset costs in excess of $20 million that result from the Agency's mandatory five-year review of Work RVUs under the Physician Fee Schedule. Our practice believes that the $20 million offset threshold set for five-year mandatory reviews in the early 1990s should be adjusted for inflation and the rising costs of providing medical care to our nation's growing Medicare population. We and other CAA members are working with Congressional leaders to address this issue legislatively. It seems nonsensical that CMS must complete the rigorous task of realigning Work RVU weights every five years only to reduce the fee schedule as a whole to pay for the review, which was mandated to ensure that Work RVUs accurately reflect the amount of time medical professionals devote to procedures and ensure appropriate reimbursement. CAA members will see their total reimbursements slashed by up to $1.65 million in 2007 as a result of the 2006 review, depending upon the method CMS chooses to offset costs. Until such time as the arbitrary $20-million cap is changed, we acknowledge that CMS must continue its actions to offset the 2006 Work RVU review.

Sincerely,

Joel Schrank, MD
Mark A. Masters, PhD
mmasters@jaxheart.com
On behalf of Jacksonville Heart Center
1905 Corporate Square Blvd
Jacksonville, Florida 32216
1-904-425-4557

Submitter : **Dr. Jeff Peterson** **Date: 08/18/2006**

Organization : **Washington Rheumatology Alliance**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Practice Expense

Practice Expense

Please see attachment

CMS-1512-PN-1927-Attach-1.DOC

Attach #
1921

On behalf of the Washington Rheumatology Alliance(WRA) representing 50 practicing rheumatologists in the State of Washington, I am writing to comment on the proposed rule published in the June 29, 2006 Federal Register 37170-37430. Our mission is to provide quality care to patients with rheumatologic diseases and we feel the proposed changes would completely inhibit us from providing this level of care to our Medicare patients.
Our primary concern with the proposed changes are the significant cuts to reimbursement to imaging services to rheumatologists and other physicians across the country. Specifically for rheumatologists, who see and treat osteoperosis, DEXA services are vital to our detection and subsequent treatment of this potentially debilitating disease. The proposed rule would reduce reimbursement for DEXA services 71%. This is far below the level for which these services can be delivered. The result will be patients will not be screened and will likely not be treated for this disease. This methodology reduces front end costs at the expense of quality of life and significantly increases back end costs. The cost of one hip replacement would pay for more than 200 DEXA scans. Screening vulnerable patients reduces overall costs to Medicare.

Our second concern is with the proposed changes to drug administration practice expense relative value units (RVUs) for infusible biologic medications. These are being billed using CPT codes 96413 and 96415 and would decline 11.8% and 10.7% respectively by 2010. Over the past several years these codes have already been evaluated and reduced by CMS. Further reductions would eliminate our ability to treat these patients effectively in our offices forcing us to send them to the hospital for these services. This would double the cost to Medicare while reducing the quality of delivered care. All of our patients strongly prefer to have infusions in our office with their physician present.

The introduction of infusible biologics has revolutionized our ability to control what were once disabling and even lethal diseases. Our patients are now experiencing normal daily activities and are productive members of society because of these medications. Many of our patients state they feel they no longer have a debilitating disease while on these medicines making the access to these treatments crucial to our practice and our mission as a society. Therefore, we strongly urge CMS to exclude DEXA and drug administration codes from the proposed changes to the practice expense rule.

Members of the Washington Rheumatology Alliance and our patients thank you for your consideration.

Jeff R. Peterson, MD
President, Washington Rheumatology Alliance
Board Certified Rheumatologist

Submitter : Dr. Robert Kopec **Date:** 08/19/2006

Organization : Dr. Robert Kopec

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

You should finalize the deal.

Submitter : Mr. Jonathan Morgenstern **Date:** 08/19/2006

Organization : New York State Society for Clinical Social Work

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Clinical social workers provide counseling and psychotherapy, the most important aspect of which is the provision of a safe and supportive setting in which a person may express and consider their feelings, leading to enhanced functioning in all areas of life. Unexpressed feelings can manifest as poor physical health, poor emotional health and destructive acting-out behaviors which are all costly to society.
Reimbursement cuts in the face of cost of living increases lead practitioners to question whether their work is valued and reduce and/or withdraw from practice.
To the extent that the reimbursement cut is related to an increase in evaluation and management codes, I request that CMS wait with this particular increase until it can increase reimbursement for all Medicare providers.

Submitter : Mr. William Cockrell **Date:** 08/19/2006

Organization : CardioVascular Associates, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : **Dr. Kevin Reed** **Date: 08/19/2006**

Organization : **MMPC**

Category : **Radiologist**

Issue Areas/Comments

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

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

I am writing to you about the proposed changes to Physician Fee Schedule as it relates to the performance and interpretation of the dual x-ray absorptiometry (DXA).

The present fee allows this valuable test to be somewhat profitable to physicians and/or hospitals. A 72% reduction in this fee would make operating this screening test a negative capital venture and in turn remove this screening test from many areas of the country.

Without this screening test available to physicians to exclude the need for treatment there will be many female patients placed on osteoporosis medications that would otherwise not.

Osteoporosis medications are expensive and have potent side effects. The cost of one or two months of these drugs are approximately the cost of a DXA scan (that is performed every two or three years).

Thus I believe that this fee reduction will in fact produce a higher burden on the CMS system, and more importantly harm patient care to the female population of America.

Dr. Kevin Reed D.O.

Submitter : **Diane Spear** **Date: 08/19/2006**

Organization : **Diane Spear**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am a clinical social worker in private practice in the borough of Manhattan in New York City. This is one of the most expensive places in the country to rent or own office space and one of the most expensive places in the country to live. The proposed increase in Medicare reimbursement for physicians results in a 14% decrease in reimbursement for Medicare providers who are not physicians. While my student loans for my advanced degree were less than those doctors typically incur, I also paid for five years of institute training and continue to pay for ongoing study. A fair increase for physicians shouldn't result in a decrease for others. A fair plan would increase reimbursement for all at the same time. A 14% decrease in Medicare reimbursement for me would mean that I will not take on any new Medicare patients, and that many other clinical social workers will do the same. Thanks for your consideration in this matter.

Submitter : Dr. Fred Isaacs **Date:** 08/19/2006

Organization : Mid-Michigan Physicians, PC

Category : Physician

Issue Areas/Comments

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

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

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

Dear Sirs:

It has come to my attention that you intend to severely reduce the reimbursement for bone density reimbursement. I am very concerned that access to this important diagnostic tool for millions of older women will be seriously compromised.

Osteoporosis and osteopenia are common and serious medical conditions for which there are few tools to develop an accurate diagnosis. Hip fracture and compression fractures of the spine cause marked disability in the form of hospitalizations, nursing home admissions, high use of home health care and physical therapy and other uses of medical services. The patients suffer unimaginable pain and many die (in some studies up to 30% of elderly women with hip fracture die within 1 year of the fracture). Treatment of osteopenia and osteoporosis prior to fractures can significantly reduce the morbidity and mortality of these patients.

The majority of patients benefiting from osteoporosis testing (bone density testing) are in the Medicare age group. Although cost sharing by shifting the cost of testing to those younger patients with commercial insurance is often seen as a method of keeping the cost of testing down for older patients (the Medicare population), i.e. commercial insurers paying higher rates than Medicare which allows hospitals and physicians to survive by balancing out their payer mix, this is increasingly impossible for those of us who primarily serve the elderly.

At the new fee schedules you are proposing, most of us in private practice will be unable to even pay our expenses for DXA scanning. This will cause us to cease to provide this valuable service to our patients. Even large hospital systems will have difficulty with these fees although hospitals have the already unfair advantage of charging facility fees for the same services provided at much lower rates in the community by physician groups. This will severely limit the availability of this valuable service and many women will forgo testing for a critical disease of the elderly.

As part of a large physician group and as an internist with primarily geriatric practice, I am requesting that you new fee schedule for DXA testing be put on hold and that you re-evaluate the true cost and value of this important service. Simply not testing for an important disease will not make it go away in our rapidly aging population.

Sincerely,

Fred Isaacs, MD

Submitter : Ms. Gail S. Levinson LCSW **Date:** 08/19/2006

Organization : Clinical Social Work Association

Category : Health Care Provider/Association

Issue Areas/Comments

Practice Expense

Practice Expense

I am a License Clinical Social Worker in Wilmington, DE, Treasurer of the Clinical Social Work Association and President of the Clinical Social Work Society of Delaware. I write to comment on the proposed CMS reimbursement rates outlined in CMS-1512-PN.

As it is, CSWs are reimbursed a rates lower than psychologists for the same procedure codes. The notion that we face even LOWER fees at all strikes me as unconscionable.

As an independent practitioner my fees have not been increased from any entities for 10 years! At the same time all other costs of living and doing business have gone up. In particular, my own health insurance premiums have increased from $215.00/month in 1996 to $764.00/month...or, 281%! Insuring myself is by far my largest expense!

I have numerous colleagues who provide excellent service to Medicare and other clients actually are going without all important health insurance for themselves as they try to bear the other costs of living whick likewise are increasing. Given that social work has traditionally been a female dominant field this means that the ranks of the 'professional uninsured' is increasing among females (often middle aged when premiums are higher) compared to males.
I wonder how many HHS and other government employees have gone 10 years without any raises? How many of these hard working employees are faced with, not only no increases in pay, but now actual REDUCTIONS in their income? We know that none of them are living without excellent health insurance coverage that extends to their families members. (If I had a spouse and children my same Blue Cross Blue Shield Plan premium would cost $2,293.79/month..and this is before any co-pays and other out of pocket expenses we all face!)

Clinical Social Workers who provide 41% of the nation's mental health services (CSWF, 2005), are often the only mental health clinicians available to the nation's elderly, disabled and military veterans.

For two years I have participated on a State of Delaware Health Care Commission study looking at the severe shortages of mental health services for our state residents. Continued DECREASES in payments will only serve to make this problem worse as many collegues are walking away from the stressful, money losing endeavor.

Reduction rather than increase in payment will only serve to compound these shortages in providers. Any decisionmakers who find wisdom in moving forward with this effort should, quite frankly, be ashamed of themselves.

Sincerely,

Gail S. Levinson LCSW
Wilmington, DE

Submitter : Kelly Dow **Date:** 08/19/2006

Organization : Accelerated Rehabilitation Centers

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am a healthcare provider that has been working in the field of Physical Therapy for over 10 years. I worked as a PT Technician for 3 years, then as a licensed PT Assistant for 5 years, and am currently working as a licensed Doctor of Physical Therapy. The majority of my experience is in out-patient orthopedics, and I am currently working with an Orthopedic, Sports Medicine practice in Illinois. I have been a member of the Iowa Chapter APTA for the first 8 years of my career, and currently a member of the Illinois Chapter of the APTA.

I wish to comment as a young, hard working, dedicated and determined Doctor of Physical Therapy, on the June 29 proposed notice that sets forth the proposed revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule. I urge CMS to ensure that severe Medicare payment cuts for physical therapists and other healthcare professionals do not occur in 2007.
" These proposed cuts clearly undermine the purpose of the Medicare system that maintains patient access to healthcare and achieves a higher standard and quality of care. These cuts could jeopardize services to millions of elderly and disabled individuals in need.
" The current SGR formula is projected to trigger a cut in payments in 2007, with similar forecasted cuts in the foreseeable future, totaling nearly 40% by 2015. The impact of these cuts will be further compounded by a budget neutrality adjuster that would impose even more cuts atop the SGR. It is perverse to impose policies that stock-pile cuts on top of cuts.

Thank you Mr. McClellan for your time and consideration of my comments.

Sincerely,
Kelly Dow PT, DPT

Submitter : Mr. Jon Nugent **Date:** 08/19/2006

Organization : premier rehab

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-1936-Attach-1.TXT

CMS-1512-PN-1936-Attach-2.DOC

Attach 77
1936

Premier Rehab

Home-Based Outpatient Therapy

To Whom It May Concern:

My name is Jon Nugent, I am a physical therapist who recently started a business providing home-based outpatient rehab to patients who otherwise would not be able to access outpatient rehab. My business is primarily geriatric and involves significant non-billable travel time. Therefore, the continuation of my business is dependant upon achieving adequate Medicare reimbursement. I am dismayed by CMS proposal to revise the the methodology for calculating practice expense RVUs under the physician fee schedule which would trigger a 4.6% reduction in payments to physical therapists. I would recommend that CMS transition the changes to the work relative value units (RVU) over a 4 year period to ensure that patients continue to have access to health care services. Although there is an increased payment for E/M codes, physical therapists cannot bill for these codes and therefore will derive no benefit from increased payment. The value of all health care providers, not just physicians, should be acknowledged in payment policy.

Thank you for your consideration.

Sincerely,

Jon Nugent, PT
Premier Rehab

Submitter : Mrs. Emily Morgan McClain **Date:** 08/19/2006

Organization : The Sacred Path, LLC

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in Greenville, SC 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 nations mental health services (CSWF, 2005), are often the only mental health clinicians available to our nations elderly. I am concerned about the impact these cuts will have on my ability 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 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.

Respectfully submitted,

Emily Morgan McClain, LISW-CP

Submitter : Dr. John Laur **Date:** 08/19/2006

Organization : University of Iowa Hospitals and Clinics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The way the CMS policy is now, we anesthesiologists face huge payment cuts in order to support overhead increases in costs for some specialties. This proposed change in PE methodology hurts the specialty of anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is very outdated and significantly underestimates true expenses and costs. CMS should collect new information on overhead expenses and replace the ten-year-old information currently in use. The ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. There is no reason to not do this.

CMS must address the issue of anesthesia work undervaluation or our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine.

Submitter : Mr. Armand Ball **Date:** 08/19/2006

Organization : none

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My concern is your plan to reduce reimbursement of medical expenses for mental disability issues. Why would you decide to reduce the expense for mental health professionals when another report recently pointed out that many teenagers (and others) had problems because they were taking anti-depressants without medical supervision. Why create a situation where we can expect more people to do so because they can not afford the fees of mental health profeossionals and doctors?

Submitter : Dr. Elizabeth Dvorkin **Date:** 08/19/2006

Organization : APTA

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

To whom this may concern,
The purpose of my letter to comment on the June 29 proposed notice that sets forth proposed revision to work relative value units and revises the methodology for calculating practice expense RVU s under the Medicare physician fee schedule. I am a licensed physical therapist at a hospital-based outpatient rehabilitation center. Here, I get the great opportunity to work with clients of all ages and a wide variety of diagnosis, including patients with stroke in our day rehabilitation program, patients with orthopedic problems, and patients with vestibular/balance problems. Therefore, a great number of my patients qualify and use Medicare for their payment. I am a recent graduate and have been practicing for exactly one year. This proposed revision could result in a devastating future year in 2007 and therefore could ultimately affect my job security and dream of practicing as a physical therapist. The proposed change would increase the work values for evaluation and management (E/M) codes by 37%. Physical therapists cannot bill for Evaluation and Management codes and will derive no benefit from the increased payment for these work values. In order to achieve budget neutrality as required by law, the proposal will reduce the work values for all services, which includes my services, billed under the fee schedule by 10%. While increasing payment for E/M services to allow physicians to manage illnesses more effectively is important, the care from all medicare providers is important for the goals and management of the patient. As a physical therapist, I spend a considerable amount of time in face-to-face consultation and treatment with my patients. I provide the best quality of care to ultimately achieve the goals and affect my patient s functional and social outcomes so they are able to heal and return to an independent life. However, the services I provide to achieve these outcomes may be reduced in value. I am afraid that if the payment of theses services is cut so severely, access to care for the millions of elderly and disabled, including my patients who are dear to my heart, will be jeopardized. I am urging you to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. I recommend that CMS transition the changes to the work relative value units (RVU s) over a four year period to ensure that patients continue to have access to valuable health care services. Thank you so much for your time and consideration of my comments.
Sincerely,
Elizabeth D. Dvorkin, DPT
bethcooley14@hotmail.com

Submitter : **Mrs. Patricia Anderson** **Date: 08/19/2006**

Organization : **Women's Diagnostic Clinic**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-1941-Attach-1.DOC

Women's Diagnostic Clinic, Inc., an independent, specialized diagnostic imaging office in Northeastern Ohio, **very strongly opposes the proposed CMS reduction in global reimbursement for computer aided detection (CAD) CPT codes 76082 and 76083.**

Women's Diagnostic Clinic, Inc. believes that CAD's use with Mammography has produced significant results. As an additional tool used at time of screening, our *iCAD* has identified a substantial number of patients with microcalcifications not easily seen and verified other abnormalities.

Analog CAD requires the additional "practice expense" of digitizing the film prior to computer algorithm analysis. The decrease is problematic as there are no means of differentiating between digital and analog CAD utilization. CMS states that the proposed revision reflects "changes in medical practice, coding . . . ." There have been no changes to substantiate this proposed rule for the use of CAD with analog mammography.

Additionally, all CPT codes for CAD (76082, 76083) contain the phrase, "with or without digitization of film radiographic images."

Further, ***Women's Diagnostic Clinic, Inc.*** strongly believes that CMS should support all diagnostic imaging, by increasing reimbursements rather than decreasing. **WHY? DIAGNOSTIC IMAGING IS A CRITICAL PREVENTIVE TOOL as well as an EVALUATIVE TOOL in medical care.** CMS will ultimately **reduce its costs** by encouraging prevention, early diagnosis, and treatment.

Submitter : Mrs. Vicky Walters **Date:** 08/19/2006

Organization : Life Connections, Inc.

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

Dear Madam/Sir,

CMS should NOT reduce work values by 7% for clinical social workers efffective Jan.1, 2007. I am highly opposed to this proposed shift of payment from some areas of medical providers to other areas. This proposed 14% reimbursement cut for my primarily Medicare clients will create a major hardship in my practice and make it even more difficult to recruit providers to work with Medicare clients. The already low 50% reimbursement and lower-than-market-valuation of Medicare services contributes to low interest in Medicare clients.

Since EVERY provider's costs, such as liability insurance, are rising, I URGE CMS TO WITHDRAW THIS PROPOSED INCREASE IN EVALUATION AND MANAGEMENT CODES, UNTIL THE BUDGET ALLOWS ALL!! MEDICARE PROVIDERS TO HAVE AN INCREASE IN REIMBURSEMENT.
I request that CMS select a formula that does not create a negative impact for mental health providers and ask that CMS NOT approve this proposed 'top down' formula to calculate practice expenses.

I have been working with geriatric clients for the past 29 years.
Thank you for your time and attention.

Sincerely,
Vicky Walters, LSCSW

Submitter : Dr. James Manning **Date:** 08/19/2006

Organization : Internist

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I am writing to express my strong support for the revision of E&M codes currently suggested to CMS. Primary care providers are on the frontlines of health care. The current reimbursement system favors procedural and imaging reimbursement far more than it does actually examining, treating, counselling, and caring for a patient. I cannot express how frustrating it is to spend hours working with patients on a daily basis and see other medical specialties making 3, 4 or even 5x more reimbursement with no clinical responsibilities or overnight call. A surgeon and anesthesiologist gets paid MUCH more EACH for a routine tonsillectomy which takes 5 minutes than I would for taking care of a dying cancer patient for hours. Additionally, our current system provides incentives for ordering more and more expensive tests and unnecessary referrals to specialists, padding these specialist paychecks at the expense of poor patient care and increased overall expenditures. Time and time again high quality research has shown that primary care providers better outcomes, higher levels of satisfaction and much more efficient (less expensive) care. I have been in the physcian workforce about 2 years now. Of my graduating class of 30 only 2 people went in to primary care. Why would you when there is potential for 2 to 3 fold salary increase for a procedural based specialty. In the end, however, this is bad for patients, bad for healthcare efficiency, bad for the US healthcare system. Altering these RVUs is the first step toward fixing the broken primary care system. Thank you for your work in this area.

Please feel free to contact me at 252 946 3912 or manning@musc.edu if I can be of any service.

James Manning, MD

Submitter : Mr. Timothy Pennington **Date:** 08/19/2006

Organization : Creative Counseling Services, L.L.C.

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am writing you to request that CMS not reduce work values by 7% for clinical social worker. I am requesting also that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers and I am requesting that CMS not approve the proposed 'Top Down' formula to calculate practice expense. A different formula should be developed that would not negatively impact all mental health providers.

CMS-1512-PN-1944-Attach-1.DOC

Submitter : Dr. Michael Baker **Date:** 08/19/2006

Organization : Cardiology Associates of Nashville

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1512-PN-1945-Attach-1.DOC

CMS-1512-PN-1945-Attach-2.DOC

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

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

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

Submitter : Mr. Warren Aoki **Date:** 08/19/2006

Organization : Private Provider

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

As a Social Worker running a new private practice, I request CMS not (1) reduce work values for clinical social workers effective January 1, 2007; (2) Request CMS withdraw the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Medicare providers; and (3) request CMS not approve the proposed bottom up formula to calculate practice expense (4) Finally, I request CMS select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers. Social Workers provide a cost effective way already to provide services and for the most vulnerable clients. However, by reducing work values and practice expense rates, more of us will choose to work in agencies and therefore there will be fewer options for this population.

Submitter : Kaye Bock **Date:** 08/19/2006

Organization : private practice

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

CMS 1512 PN This proposed legislation would impact my practice in that I would no longer be willing to take Medicare patients for such a reduced fee. I have 30 years of extensive psychotherapy training and experience and this fee would not reflect my value. That would be a disservice to myself and my patients - cutting my fee while the economy is experiencing inflation. This would be a false economy because then the elderly would be put on more medication if their depression and anxiety is not treated by social workers. This legislation is short-sighted and does not reflect respect for the elderly and their freedom to choose the best treatment for themselves.

Sincerely,

Kaye Bock, M.S.W., LCSW, Board Certified Diplomate

Submitter : **Ms. Flo Peterson** **Date: 08/19/2006**

Organization : **Salina Regional Health Center**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

As a clinical SW practicing in an inpatient psychiatric unit, part of a regional medical center, the majority of my patients have life long mental illness which has caused them to need SS Disability and Medicare to provide very basic needs. This fiscal change chips away the basic outpatient system that supports them. Funds and supportive community services are already very limited for this segment of the population. It takes skill and knowledge of not only resources but the intricate needs of their illness to maintain these folks. Otherwise they easily decompensate and become part of the growing homeless population. Clinical social workers are specifically trained in the wide range of knowledge to help meet this need. Cutting reimbursement here will only lead to higher costs elsewhere.

I feel that increasing Medicare reimbursement at this time should be withheld for all parties until a more equitable solution can be found.

Thank you for your consideration.

Submitter : Dr. Cynthia Hazen **Date:** 08/19/2006

Organization : Raleigh Psychiatric Associates

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am a Licensed Clinical Social Worker in Raleigh, NC 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.