Submitter : Mrs. Mary Lou Ecker **Date:** 08/19/2006

Organization : NASW

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

A. Furthermore, coping with medical issues, eg: diabetes, dialysis, and thousands of others is not just a simple treatment by an injection or a blood cleaning session. These people are important and deserve our emotional support. The concept of the one-stop treatment is this realistic as an action plan for which most of those people have worked during their lives and contributed positively to our country and economy.

B. Coping with disorders i.e: obesity (heart attacks cost about 30,000.00) and mental illness, phobias or neurosis that afflict millions of working Americans. Social workers are in no way a drain on the enconomy. The costs of mental illness and institutionalization/homelessnes are more expensive than the costs of therapy.

G. Negative support for the family victims of crime and illness, can reduce funding for services to encourage to help them to develop strategies to help them continue to to work, provide for their families and contribute to Americas enomony.
H. Americas aging population, the backbone of our country, is increasingly abusing drugs and developing suicidal tendancies.
I. Career Counseling: A graduate is a valuable resource, and a career counselor (related profession) is important to make sure that that individual can do the most for himself and his/her country. Too often, graduates who do not have a good sense of direction can waste their learned skills and this imparts a loss to America as well.

J. The financial returns cant be shown on todays balance sheet but you can bet they will be on tomorrows. I ask that medicaid looks ahead at what the true costs are, the real and true values.

K. Keeping marriages together it is a foregone conclusion that divorce (attorney s fees etc& which attorneys themselves discourage) is a tremendous waste to our economy. Not all marriages can be saved, but those who wish to need an incentive to help themselves.

Mary Louise Ecker, LCSW

Practice Expense

Practice Expense

A.A Psychologist and an Anesthesiologist are PH Ds and MD s respectively. They command a much higher salary. There is no fair economic comparision between their income and the income of a social worker.

B. The occupational outlook handbook does not list the lowest range that social workers earn in certain parts of the country. Reducing this salary, - their expenses, can send them to poverty level in a family of 4. Many are self insured and have to pay out of pocket for health coverage.

C. Social workers save money. Their billable hours (eg: working under a licensed psychologist or psychiatrist (which was not targeted by the way but in the same exact field) are billed at a vastly lower rate than a session with a MD or PHD. Many doctors know that their clients don t always get reimbursement for their fees, so they will have a social worker - Who works under them, bill the client at a fractional rate and report the information back to the MD or PHD, under their direction. This profession already has built-in efficiency plans.

D. The proposal suggests a reduction in support for America s poor, the #1 primary serviced population of social workers (as opposed to the proposal s viewpoint that clients of social workers have sessions for the purpose of generally feeling better about themselves or a theraputic retreat rather than the reality medicaid funded social worker fees pay for crisis intervention, substance abuse intervention, and helping inner-city children and adults develop self-confidence enough to avoid the criminal elements of our modern world.

E. The social work profession is being targeted because a yardstick for measuring the value of what these professionals do for society is not consistent enough among the evaluators of the profession, but I believe the authors of this propoasal, if asked themselves, would agree that if the true economic value of this profession is understood better and able to be measured, a greater sense of validity and concern for the clients and the profession would develop. Example: going inside a building where residents live in poor conditions will develop greater sympathy for these residents (this is common knowledge) I ask that America not turn its back on helping its working poor keep working (children in schools and young/older adults) .

F. The proposed legislation targets another population the disabled who are working to overcome their disabilities (who choose not to be a burden on the system) require the assistance of social workers, who earn a fractional sum compared to what the disabled American workforce can produce economically. Social workers can help this group to develop efffective strategies to help them keep working in todays competitive workplace. Many of these disabled work for lower wages than most.

G. If you compare the lifestyle of anesthesia specialists, psychologists, and social workers, you will find that because of the income level of the average to lower ranges, social workers already use their own personal resources to assist their clients in receiving services, many offer sliding scale fees for those who cannot pay, and , like teachers, already use a percentage of their paycheck already to pay for business supplies. This is not true among anesthesiologists and psychologists who often own several vehicles and houses. This is just not the case with social workers, who are at the bottom of the food chain financially. (compared to MDs and PHd s)

H. Further penalizing this group will disourage new incomers to the field of social work which society itself desperately ask for their services, and mental illness in America is a real illness, just as real as drug and alcohol abuse (the primary issues served by social workers anyway) There are so many more lucrative professions than social work that a graduate can choose from, and social workers need more members. Part 1. Part 2 to follow under other issues.

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

Organization :

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Please finalize the recommended RVU increases. As hospitalized patients have become increasingly more complex, they required more of our time and resources to work on. I urge the CMS to reject any efforts to lower the overall recommended increases. Thank you

Submitter : Dr. Daniel Murphy **Date:** 08/19/2006

Organization : Dr. Daniel Murphy

Category : Physician

Issue Areas/Comments

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

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

Dear CMS,
I am writing in reference to the proposed reduction in reimbursement for DEXA scans. At a cost of 75K to 80K, it will be cost prohibitive to purchase a new DEXA scanner if the reimbursement decreases. If the equipment companies are forced to significantly reduce the cost of the scanners, technological advances and R and D will suffer. In order for the quality of bone density measurement to advance, which society (mostly this nation's seniors) will demand, we need to pay for R and D and hence continue to reimburse fairly for these services.
Unfortunately, the Medicare buget is being stressed more every day. May I recommend Medicare arrange Town Hall style meetings with physicians in every major city. Physicians and Medicare could identify areas to save money which may add up to many millions. For example, as an orthopaedic surgeon, at times I operate on a patient and would like to send them to a rehab center the day after surgery. Unfortunately, the patient has to stay in the hospital for three days before they go to rehab because this is a Medicare rule.

Submitter : Mr. Douglas Dewey **Date:** 08/19/2006

Organization : Douglas Dewey, PT,PC

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

I have been in practice for 36 years, 30 as an owner/administrator/therapist. If the prosed changes go into effect, I will have to stop treating Medicare patients. My re-imbursement levels will drop below my per patient costs for fixed expenses, leaving no room for profit. The added effect of the 2007 Conversion Factor Adjustment, will result in a 10% reduction in my NET reimburesement. Added to this is changes which will reduce how much I can bill resulting a potential significant decrease in gross billings. These changes will force many health care providers out of the Medicare system. Thanks for listening.

Submitter : Steven Steiner **Date:** 08/19/2006

Organization : Steven H. Steiner, LCSW

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I understand you are considering reducing reimbursement to clinical social workers effective 1/1/07. I have had a psychotherapy practice for 12 yrs and mkust say that is quite unreasonable given current costs for maintaining a psychotherapy practice. I recently applied to become a Medicare provider. If this reimbursement reduction is approved I would consider not participating with Medicare. Thank you for taking my comments.

Submitter : Dr. Stephen Ackerman **Date:** 08/19/2006

Organization : Nebraska Heart Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-1955-Attach-1.DOC

Attach #
1955

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

08/18/2006

Dear Dr. McClellan:

On behalf of Nebraska Heart Institute and our 33 individual practicing physicians, 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.

Nebraska Heart Institute has seven offices across the state, including four outpatient cath labs in Lincoln, Omaha, Hastings, and North Platte, Nebraska. Before Nebraska Heart Institute's cath labs in Hastings and North Platte were installed, patients had to travel hours to receive elective outpatient catheterizations, and our labs in those relatively rural areas have significantly improved patient care and access to proper diagnostic testing for suspected coronary artery disease. We perform 3,000 heart catheterizations in these four labs 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") 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.

Because the cost data for catheterizations in particular do not reflect the actual cost of providing heart catheterizations, we may be forced to close our four Nebraska catheterization labs, as we would be losing money on every single procedure. This would move 3,000 elective catheterizations to other Nebraska hospitals, which would still be able to cover the cost of doing a catheterization. We believe this would cause a serious patient access problem for patients needing emergent catheterization in a hospital setting. Door-to-Balloon Time, an important measure of the survival of acute cardiac patients, would most certainly increase due to the large numbers of elective procedures in hospital labs. We believe that shifting elective catheterizations with low complication rates to hospital labs would create an inability to provide the high-quality care Nebraska's hospital patients currently receive.

Sincerely,

Submitter : Ava Louise Stanton **Date:** 08/19/2006

Organization : Private Practice

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

A 14 percent reimbursement cut will mean it will not be cost effective fro me to serve Medicare patients. The paperwork is so cumbersome now that a pay reduction will not be worth providing the service.
Please do not to reduce work values for clinical social workers effective January 1, 2007;
Please withdraw the proposed increase in evaluation and management codes until there are funds to increase reimbursement for all Medicare providers
Please do not to approve the proposed bottom up formula to calculate practice expense. Instead, select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Submitter : **Ms. Virginia Reynolds** **Date: 08/19/2006**

Organization : **Self Employed**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Hope it will be considered that social workers tradionally have provided services at a much lower fee scale than psychologists or psychiatrists for mental health services. Please do not lower the reimbursement for this profession. Item #CMS 1512 PN. Thank you.

Submitter : Mr. Lou lipsitz **Date:** 08/19/2006

Organization : Mr. Lou lipsitz

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am extremely disturbed by the intention of cutting back on reimbursements for social workers. Social workers are already underpaid by Medicare. Many of us will have to reconsider whether we will be able to continue providing psychotherapy services if such cuts are made. This would be unfortunate for all concerned especially our older clients. Equal pay for equal codes (such as CPT 90806) should prevail.

Submitter : Virginia Bristol **Date:** 08/19/2006

Organization : Virginia Bristol

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

I am writing with regard to the proposed cuts in Medicare reimbursement for clinical social workers. I am a licensed clinical social worker in the state of North Carolina. I have been providing services to disabled and elderly clients for over 25 years. About one third of my practice consists of clients who participate in Medicare. I know many clinicians in this area who refuse to treat Medicare clients because of the already low reimbursement rates. By lowering this even more, you stand to lose even more participating providers. Clinical social workers provide about 41% of all mental health services in this country and more represented in rural areas. We are already paid less than psychologists even though we provide similar services and use the same CPT codes. Please, please reconsider the plan to lower our reimbursement rates. I truly enjoy my Medicare clients and would hate to have to stop serving that segment of the population.
Thank you,
Virginia Bristol, MSW, LCSW

Submitter : Dr. Carrol Gordon **Date:** 08/19/2006

Organization : Dr. Carrol Gordon

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

The reduction of reimbursement for clinical social workers needs to be maintained at the same level in 2007. It is already lower than the reimbursements for all other mental health providers

Submitter : **Ms. Sibyl Wagner** **Date: 08/19/2006**

Organization : **Sibyl Wagner, MSW LCSW**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

As a Licensed Clinical Social Worker and as a member of the Clinical Social Work Association, I am opposed to the proposed cuts to reimbursement rates as proposed in CMS-1512-PN. As my clients are reaching 65, I plan to apply to be a Medicare Provider so I can continue to serve them.Lowering the rate of reimbursement for providing care to Medicare clients, would make it more difficult to serve these clients.

I have worked ever since I received my MSW from the University of Pennsylvania School of Social Work in 1975. I have served as an Assistant Professor in the UNC School of Medicine, providing weekly supervision of psychiatric residents in their clinical care for years.The Dept. of Psychiatry recognized that clinical social workers provide a large percentage of psychiatric care and that we have special expertise in clinical services.

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.

Sibyl Wagner,LCSW

Submitter : Bert Levy **Date:** 08/19/2006

Organization : Bert Levy

Category : Health Care Professional or Association

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in Kentucky 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 provide 41% of the nations mental health services (CSWF, 2005), are often the only mental health clinicians available to our nation's elderly. The proposed 14% cuts will place another hardship on providers who are already at a disadvantage because we receive 25% less than psychologists for the same service and procedural codes, ex. 90806.

Not only does this impose an income hardship, it further challenges the ability to continue providing adequate care for the growing number of seniors in need of services. In other words, the financial harm this does to LCSW's will certainly impact those who we want to serve, by having to rethink the numbers that can be seen.

Therefore, I request, for the benefit of all parties concerned, that you WITHDRAW THE CURRENT PROPOSED CUTS TO LCSW MENTAL HEALTH PROVIDERS. In place of that, please consider changing the inequitable reimbursement system that currently exists and implement EQUAL PAY FOR THE SAME CODES.

Submitter : John Vickery **Date:** 08/19/2006

Organization : John Vickery

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a fourth year medical student and in the process of making a definite decision on what field of medicine to enter. I wish that I could make that decision based solely on what I would enjoy the most. However, I cannot ignore the realities of the future of the economic landscape of healthcare. I am nervous about entering a field that relies very heavily on Medicare and Medicaid for reimbursement. With the propose changes to the work values for evaluation and management services, I feel engouraged, and this and other positive signs weigh heavily on my decision for a future field of practice.

Submitter : Dr. Brian Itagaki **Date:** 08/19/2006

Organization : Brian H. Itagaki M.D., Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1512-PN-1964-Attach-1.DOC

Attach #
1964

Brian H. Itagaki, M.D.
420 E. 3rd Street, Suite 704
Los Angles, California 90013-1646

August 16, 2006

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

RE: CMS-1512-PN

Dear Sir:

I am a Japanese American Board-Certified orthopaedic surgeon in sole proprietorship in Los Angeles, California, serving a minority Asian population. A majority of my patients are Japanese who visit me in my office in Little Tokyo.

I have been using a fan-beam bone densitometer (DEXA) machine since March 2002 with a 60-month least rent of $1550.14. The maintenance contract for this machine costs me $953.00 per quarter for 3 years. These DEXA scans with the appropriate prescribed medications have helped my patients experience less hip, wrist, and back fractures. I would like to continue to provide DEXA services to my patient, however, if fee schedules are cut to $38 per scan, I will not be able to lease the DEXA machinery and provide the services to my patients since I will need more than 60 scans a month in order to pay for the operating costs. Please also take into consideration the operating costs of my the radiographic technicians who are compensated at $30 per hour.

The DEXA scans have prevented my patients from hospital operations and stays costing $25,000 or more. This diagnostic tool has given them a much better quality of life. I am convinced that the DEXA scans are truly a medical necessity to prevent hospital and nursing home stays costing our government millions of dollars.

Please consider my appeal to reconsider the future cuts in the reimbursement of DEXA scans. I would like to serve my community in their total orthopaedic care and without these DEXA scans, I will not be able give them the complete care that is needed.

Sincerely yours,

Brian H. Itagaki, M.D.
Orthopaedic Surgeon
Chief of Surgery, St. Vincent Medical Center
Los Angeles, California

Submitter : Ms. Kristin Froehlich **Date:** 08/19/2006

Organization : Clinical Social Work Society of Delaware

Category : Health Care Provider/Association

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in New Castle County, Delaware 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 social workers' abilities to continue to provide services to Medicare enrollees.

Licensed clinical Social Workers are reimbursed for (CPT) Code 90806, 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. Social workers provide more services for Medicare enrollees than psychologists since they are educated and trained to treat the whole person in their environment rather than more specific issues on which a psychologist might focus.

Lowering the reimbursement rates further, as the 14% proposed cuts would,would make it impossible for social workers to cover business expenses and, therefore, would make it difficult to continue serving Medicare enrollees.

I request that you 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.

Thank you.

Kristin Froehlich, LCSW

Submitter : Dr. David Dull **Date:** 08/19/2006

Organization : Spectrum Health

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses.
CMS should gather new overhead expense data to replace the decade-old data currently being used.
ASA, many other specialties, and the 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.
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 : Ms. Rebecca Hall **Date:** 08/19/2006

Organization : South Carolina Society for Clinical Social Work

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

To whom it may concern:
I am a Licensed Clinical Social Worker in South Carolina 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 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.
Sincerely,
Rebecca Hall, LMSW, SCSCSW Membership Committee Chairperson

Submitter : **Mrs. Michele Seligman** **Date: 08/19/2006**

Organization : **NASW**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Comment on CMS-1512-PN
If this bill is passed it will adversely effect our senior citizens who are most in need. Cutting Social Worker's reimbursement will make them unable to see Senior Citizens in private practice. I have a private office and must be able to pay my rent and other bills. I find that senior citizens need to use mental health services since they have a high rate of anxiety and depression related to illnesses and losses associated with aging. Please do not limit their access to mental health service.
Thank you.
Michele Seligman LCSW,BCD

Submitter : **Denise Corrado** **Date: 08/19/2006**

Organization : **Denise Corrado**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

Please do not reduce the rate paid to Clinical Social Workers. In comparison to PhD providers, we provide services that are already a bargain for Medicare. How are we expected to stay in business when Medicare's response (to dramatically increasing operating costs) is to reduce our income? My work week is already increased to 50 and 60 hours a week in order to make ends meet. Help me understand, isn't the work that we provide to our Seniors of value?

Submitter : Dr. Keith Demirjian **Date:** 08/19/2006

Organization : Primary Care Northwest

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

see attachment

CMS-1512-PN-1970-Attach-1.TXT

Attach #
1970

August 19, 2006

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

From: Primary Care Northwest
c\o Keith Demirjian, MD
1812 South J Street, Suite 102
Tacoma, WA 98405

To Whom It May Concern,

It has come to our attention that the Medicare global reimbursement for the performance of axial DXA scans will be reduced from the current approximate of $140 to the proposed $38 over the next four years. This cost reduction will make the performance of DXA scans prohibitive for the average practitioner, making access to DXA's very limited, and forcing the bulk of these tests to be done in large x-ray or hospital facilities. Our clinic has nine fulltime primary care providers, and under the new proposal our profit margin for DXA's would be negligible, or a net $1200/year. (Receipts would be $26,600, or 700 tests @ $38. Costs would be $25,400, or technician fee $7800, rented space $3000, warranty $2000, bank note/year $12,000, and supplies $600). Our scanner is already several years old, and we have the least expensive model to maintain. Having to purchase a new scanner would make this a money-losing proposition. With the ever-increasing overhead expenses and flat or decreasing reimbursements, primary care providers must look to adding additional services to maintain the bottom line. We can no longer provide services that are break-even propositions. Profiting from services that we would normally refer out is a win-win situation for providers and their patients. If the foregoing proposal is carried out, women's access to this test will be severely strained. We sincerely hope you take these matters into account while trying to reach a fair reimbursement for this valuable test.

Sincerely,

Keith Demirjian, MD

Submitter : Mrs. Janie Allen **Date:** 08/19/2006

Organization : VeriCare

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a clincal Social Worker. I provide psychological services to Pt's in nursing homes. I drive to nursing homes in other towns to see Pts. A 14% reimbursement cut will affect my practice greatly. When you factor in the increase in gas, I will not be able to continue delivering services. I am requesting that CMS not reduce work values for clinical socialworkers effective Jan. 2007. I respectfully request that you withdraw the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Medicare providers. Please select a formula that does not create a negative impact for clinical social workers who already have very little practice expense as providers.
Thank You for your attention.
Janie Allen LCSW

Submitter : Ms. Eleanor Perlman **Date:** 08/19/2006

Organization : Private Practice

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am writin g to object to the 14% proposed cut to social workers' payments as of 1/1/07. I have been a practicing social worker since 1975. I will not be able to continue to see patients if my salary is further decreased. This would be unfortunate, as social work is a field in which experienced practitioners are far more successful, overall, in their work. They are able to diagnose and evaluate more quickly, and have had years of experience in treating patients. As most prices are going up, we will be forced to treat only private-paying clients. This will leave thousands of people at risk, as they will be unable to receive effective therapy services, and government will pay more to hospitalize people who could have been treated far less expensively, and more effectively, on an ongoing, outpatient level.

Submitter : Dr. Jane Potter **Date:** 08/19/2006

Organization : American Geriatrics Society

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 : Loretta Marx **Date:** 08/19/2006

Organization : Kirkland Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

I have practiced as a Physical Therapist for 30 years. I have seen many changes in the Medicare remibursement during this period. I am very fearful that Medicare patients will not have the assurance of access to valuable health care services with the cut backs expected if CMS changes the RVU's. I am suggesting that CMS transition the changes to the RVU's over a four year period. The following out lines the rationale:
RATIONALE 1. Under current law, the Sustainable Growth Rate (SGR) formula is projected to trigger a 4.6% cut in payments in 2007. Similar cuts are forecasted to continue for the foreseeable future, totaling 37% by 2015. The impact of these cuts would be further compounded by a budget neutrality adjuster proposed in the 5-year review rule that would impose additional cuts on top of the SGR. It is unreasonable to propose policies that pile cuts on top of cuts. 2. Physical therapists cannot bill for E/M codes and will derive no benefit from increased payment. Therefore, 2007 will be a devastating year for physical therapists and other non-physicians who are not allowed to bill for these E/M services. (Note: CMS does not have the authority to alter the regulations to allow physical therapists to bill for E/M services; these comments would not be an appropriate place to make such arguments.) 3. These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment for these services is cut so severely, access to care for millions of the elderly and disabled will be jeopardized. 4. CMS emphasizes the importance of increasing payment for E/M services to allow physicians to manage illnesses more effectively and therefore result in better outcomes. Increasing payment for E/M services is important but the value of services provided by all Medicare providers should be acknowledged under this payment policy. Physical therapists spend a considerable amount of time in face-to-face consultation and treatment with patients, yet their services are being reduced in value. "

Thank you for your consideration,

Loretta O. Marx PT, MHA

Submitter : Mrs. nancy petrides **Date:** 08/20/2006

Organization : Stonebrook Counseling Associates, PLLC

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

Please consider not lowering the amount of reimbursement. Most insurance companies I contract with have increased their fees by 10%. Thank you for your consideration.

Submitter : Mr. C. Timothy Richardson **Date:** 08/20/2006

Organization : Medical Arts Rehabilitation, Inc.

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

C. Timothy Richardson, PT, MTC
Medical Arts Rehabilitation, Inc.
506 4th Ave W.
Palmetto, Florida
34221-8746

20 Aug. 06

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services (CMS)
US Department of Health and Human Services
Attention:CMS-1512-PN
PO BOX 8014
Baltimore, MD 21244-8014

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

Dear Sir,

I am a physical therapist in private practice (PTPP) in Bradenton and Palmetto Florida. I treat primarily outpatient orthopaedic patients with sprain and strains of the neck and back, post-surgical conditions of the knee and shoulder (TKR, THR, etc.) as well as a wide variety of debilitating conditions that affect mobility in otherwise ambulatory patients.

As an individual, I have been practicing for 14 years and as a business we have been operating for 24 years. We have three locations and seventeen employees. We have been providers for Medicare patients for the entirety of our existence. We bill under the Physician Fee Schedule. Approximately 40-50% of our work is with Medicare patients.

I wish to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units (RVU) and revises the methodology for calculating practice expense RVUs under the Medicare Physician Fee Schedule.

To provide a stable marketplace for physician services, CMS should phase in, over four years, the proposed revisions to the work relative value units for Evaluation and Management (E/M) codes. This phased-in approach would be consistent with CMS goal of ensuring patient access to quality healthcare.

Any dramatic change in Medicare fees in a one-year time frame could jeopardize my ability to retain my staff, re-invest in my business (Eg: medical information technology) and provide for a reasonable profit.

A return to shareholders should be viewed as a cost to the business to entice shareholders to invest. From a policymaker s standpoint, CMS needs to consider the incentive for physician shareholders to continue to provide services to Medicare patients.

The projected shortfall in physician services is not a projection for us. It is here. I cannot readily hire a physical therapist at a reasonable rate.

To prevent a worsening of the shortage of physicians and physician services and to guard against a loss of patient access to quality healthcare services I recommend a four- year, phased-in revision to the work relative value units component of the physician E/M codes.

Thank you for your time and attention to this matter.

Sincerely,

C. Timothy Richardson, PT, MTC

Submitter : Ms. Ellen Edelman **Date:** 08/20/2006

Organization : grant writer

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Re: Negative impact on mental health care availability for the elderly.

The larger impact of the fee changes for social workers, psychologists and psychiatrists will be on the elderly who may not be able to afford mental health care at a time in their lives when it may be especially needed because of the normal losses that happen late in life: loss of job/professional identity (because of retirement), loss of physical abilities and/or health, loss of independence because of failing health and/or finances, loss of life partner through death, loss of friends (who die more frequently than do friends in our younger years), loss of value as a person with an opinion (social bias against age/ageism)... and probably more. Depression in the elderly is frequent and is frequently not diagnosed or recognised. Elderly widowers are more liable to suicide. And so forth. Co-pays for mental health care are already high for those on a fixed income. Because of the fee reductions, co-pays will go even higher. Depression responds best to a 2-part treatment: meds and talk therapy, which needs to be at least once a week - something that already many elderly find too expensive.

Loss of mental health care will of course impact negatively on the individual elderly - but will also impact negatively on society which will lose the vibrant resource of experience and expertise which the elderly can contribute.

Submitter : Julie Hovrud **Date:** 08/20/2006

Organization : Julie Hovrud

Category : Health Care Provider/Association

Issue Areas/Comments

Practice Expense

Practice Expense

As a North Carolina Licensed Clinical Social Worker and a member of the Clinical Social Work Association, I am writing to comment on the proposed CMS cuts for reimbursement rates as proposed in CMS-1512-PN. As you may already know, 41% of mental health services are provided by Clinical Social Workers and are often the only clincians in mental health available for the elderly. The cuts that are proposed concern me as it will impact my ability to continue providing services to clients with Medicare. Reimbursement for Clinical Social Workers is already 25% lower than the rate psychologists receive for the same 90806 CPT codes. The same types of services are being provided, yet there is inequity in reimbursement. With the current 14% proposed cuts, it would make it impossible for me to cover the business expenses incurred and would may it difficult, if not impossible, to continue serving Medicare clients.

I am requesting that the proposed cuts in reimbursement for LCSW mental health providers be withdrawn and also to consider making changes to the current reimbursement system exists and replace it with an equitable pay distribution for codes.

Submitter : Mr. Martin Lavine **Date:** 08/20/2006

Organization : PUSH GYM Ftiness and Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

Hello, in a nutshell, it seems from any standpoint it is difficult to cut our reimbusrement fees for any reason. As a profession, our cost of schooling has risen sharply over the years and student loan costs are high. Many schools across the country have added an extra year of school for the entry level doctorate program as wel. Our reimbursement fees are already cut, for example in Colorado, Cigna reimburses only $51.00 per session regardless of treament options or time involved. That is hardly enogh to cover overhead costs. Costs for our supplies are high, rent to maintain a clinic are rising as well. So you get shorter treatment times and poor outcomes, crowded clinics and patients finding it more difficult to find clinics to see them. As the fees for private insurance skyrocket, how are we as a profession able to sit and watch our reimbursements drop while insurance companies raise their rates. There needs to be better management of these funds as these numbers do not seem to work from a basic standpoint of accounting.
Thank you for listening to me, and feel free to contact me
Martin Lavine MS, PT
Owner PUSH GYM Fitness and Physical Therapy
Denver, Co 303-903-8174
mlavinept@yahoo.com

Submitter : **Ms. Elizabeth Crosland** **Date: 08/20/2006**

Organization : **Waters Edge Counseling**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in South Carolina 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 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.

Elizabeth Crosland, LISW-CP
400 Mills Avenue #309
Greenville, SC 29605
(864)325-7174
>

Submitter : Dr. J. DAVID BANNON **Date:** 08/20/2006

Organization : J. DAVID BANNON MD PC

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

WE PURCHASED A GE LUNAR PRODIGY DXA SCAN IN 2002.OUR MONTHLY LEASE IS
1265.81 ORIGINAL COST 41,000. WE PAY A CERTIFIED TECH 22.00/HR TO PERFORM THE SCAN 4 HOURS A WEEK AND A DENSITOMITRIST 39.00 HOUR TO INTERPRET THEM 4 HOURS A WEEK. WE AVERAGE 16 SCANS A MONTH.
OUR AVERAGE REIMBURSEMENT IS 130.00 FROM MEDICARE. HOW CAN WE POSSIBLY CONTINUE THIS PREVENTATIVE HEALTH CARE WHICH IS AN IMPORTANT COMPONENT OF ORTHOPAEDIC CARE IF WE RECEIVE A 4.6% REDUCTION FOR THIS SERVICE FROM MEDICARE?????????????

Submitter : **Dr. Davidson Hamer** **Date: 08/20/2006**

Organization : **Boston Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my support for increased payments to physicians for outpatient visits for HIV-seropositive patients. We are currently underpaid for the work required to appropriately manage these complex patients.

Submitter : **Betsy Amey** **Date: 08/20/2006**

Organization : **Maryland Legislative Council of Social Work Organi**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2006
Re: File Code CMS-1512-PN
Dear Sir or Madam:

As a Licensed Certified Clinical Social Worker in Maryland, I am appalled at the proposed 10-14% reimbursement fee cuts for mental health services by us and other non-physician practitioners. While these cuts will also adversely affect physicians'ability to meet expenses, those of us who are charged with providing similar services at only a percentage of the physician rate (already an inequitable situation) would be devastated. The current allowed rate for outpatient psychotherapy has not kept pace with inflation and already is significantly below what it should be. Reducing compensation further to those who render vital mental health treatment to an ever increasing older and disabled population would shake the necessary supports to provide basic services.

Please see my attachment for my complete comment.

Sincerely,
Betsy F. Amey, MSW, LCSW-C
Medicare Provider

CMS-1512-PN-1983-Attach-1.DOC

Attach #
1983

August 20, 2006

Re: File Code CMS-1512-PN

Dear Sir or Madam:

As a Licensed Certified Clinical Social Worker in Maryland, I am appalled at the proposed 10-14% reimbursement cuts for clinical social workers and other primarily non-medical practitioners. While these cuts will also adversely affect physicians and their ability to meet expenses, those of us who are charged with providing similar services at only a percentage of the physician rate (already an inequitable situation) would be devastated. The current allowed rate for outpatient psychotherapy has not kept pace with inflation and already is significantly below what it should be. Reducing compensation further to those who render vital mental health treatment to an ever increasing older and disabled population would shake the necessary supports to provide basic services.

There seems to be a widespread misconception that health care professionals are extracting exorbitant fees for their services, and that this is the cause of so-called "medical inflation." Like many other clinical social workers, my standard (full) fee has increased only 6 % from 1992-2006 while the U.S. inflation rate has been 14.53%. I have struggled to pay overhead expenses with less income per client.

Medicare allows me to charge only 74% of the fee I charged back in 1992 for an individual therapy session, and still charges my clients a portion of that for co-pay. At present (fourteen years of practice later), the Medicare rate is now only 62% of my fee. With a 10-14% reduction in *that* rate, I would be collecting only 53-56% of my usual fee. This is an undue hardship.

As a person who subscribes to the Code of Ethics of my Social Work Profession, I have felt compelled to serve those who are unable to pay the full fee, and therefore have remained a Medicare provider all of these years. However, if the CMS reduces the allowed benefit 10-14% further, I shall no longer be able to serve Medicare clients. Many practitioners will be in this same situation; only those large entities with other sources of financial support (state funds, research grants, etc.) will be able to serve the ever-growing population of Medicare clients.

This is already a problem when trying to find psychiatric (medication) treatment for clients. Even though a psychiatrist can charge 30% more than a Licensed Clinical Social Worker for an evaluation or therapy session (according to the odd Medicare formula), many psychiatrists find this too low a fee to support the operation of their practice, and do not accept Medicare clients.

Where will these Medicare clients go for treatment? To already underfunded and struggling public programs? These programs stay afloat (barely) by employing less experienced, less educated staff to provide less individuated care at low salary. There are already long waiting periods for such programs, especially for chemical dependency

treatment services. There is no consideration for the patient's choice of therapist in these programs. Those who earn an income above the designated percentage of the poverty rate are usually declared ineligible to access these programs. Thus, Medicare recipients who are financially independent may have to pay out of pocket for their treatment needs, at a much higher rate, in order to access well-qualified professionals in a timely fashion.

This situation is hardly what the wise people who created the Medicare program envisioned. Please rethink these proposals and:

1. Refrain from reducing work values by 7 % for clinical social workers effective January 1, 2007;
2. Withdraw the proposed increase in evaluation and management codes for physicians until funds are available to increase reimbursement for all Medicare providers; and
3. Change the again proposed "Top down" formula to calculate practice expense, and select a formula that does not create a negative impact for mental health providers.

I and many others want to be able to provide quality mental health and substance abuse evaluation and treatment to any who may need them.

Sincerely,

Betsy F. Amey, MSW, LCSW-C
1205 Stevenson Lane,
Towson, MD 21286

CC: Senator Barbara Mikulski
Senator Paul Sarbanes
Congressman Benjamin Cardin

Submitter : Dr. Feizal Waffarn **Date:** 08/20/2006

Organization : University of California Irvine Medical Center,

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I oppose the CMS proposed 10% reduction in physician work RVUs for Medicare. It ripples thru Medicaid and the private sector health insurance plan payors with a major unforeseen negative impact on physician compensation. I am a pediatrician working in a tertiary care safety net hospital.

The CMS review of Evaluation and Management services for updates on physician work RVUs is appropriate, as there is common agreement that physician work in E&M services has been undervalued. Any increases must be budget neutral under current law. The CMS proposal to apply a 10% negative physician work RVU adjuster to all codes with physician work in an effort to achieve budget neutrality for the increases is strongly opposed.

"The 10% across the board reduction may be a simple adjustment method, however, any simple reduction is illogical, inappropriate and unfair.

"Across the board -10% reductions will damage the integrity of physician work within the RVU system. The physician work E&M changes are logical and they should be implemented without destroying the relative weight of the physician work amounts against the practice expense and malpractice values, the other two components of physician total relative value.

"Physician work will be relatively devalued (the -10% reduction) against the unchanged malpractice and overhead amounts.

"If budget neutrality is required, it should be factored into the 2007 conversion factor, without changing the three components that comprise total physician Medicare payments. This will keep the balance between the three components relatively logical and intact.

F Waffarn MD
Chairman Dept of Pediatrics
UCIMC, Orange CA

Submitter : Jim Kreider **Date:** 08/20/2006

Organization : Kreider Consulting, LLC

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am very concerned about the impact of the proposed 14% reembursement rate cuts for mental health Medicare providers. We provide sevices to Medicare clients at rates that currently barely cover our costs, let alone make it possible to spend time on unreembursed activities such as coordinating with medical doctors, other providers, or family members. The net result is that we will need to exclude these clients from our practices in that we will not be able to provide adequate care for such low pay. Consequently, clients risk being underservered, or may need to seek higher cost services from other providers, or seek services from less qualified providers. The obvioius risk is that service quality will go down and cost (which will likely include hospitalizations if more accessable services are not available) will go up.

I can appreciate the need to contain costs, but a short term reduction in cost with a long term increase is not cost effective. Please withdraw the proposed 'top down' formula to increase reembursement for physicans at the expense of mental health providers and consider seeking funds that would allow increases in reembursemnet to all Medicare providers. Thank you for your consideration in this matter.

James W. Kreider

Submitter : **Ms. Jill Gaumer** **Date: 08/20/2006**

Organization : **Counseling and Mediation**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Practice Expense

Practice Expense

I wish to comment on the proposed CMS cuts to reimbursement rates as proposed in CMS-1512-PN.

I am a Licensed Clinical Social Worker in Newark, Delaware and Elkton, Maryland. I am the Public Relations Director for the Clinical Social Work Society in Delaware. I have recently become active with the Clinical Social Work Association as it moves toward becoming a national voice for Clinical Social Workers. I am in full time private practice and do all of my own scheduling and billing. Because of this I am very aware of the reimbursement levels of most major insurance companies and the hassle (for lack of a better word) of getting paid.

I have taken the position that I do not become paneled with companies that do not reimburse at a reasonable rate. I simply do not take these clients. It would be bad business on my part to accept these low fees.

If the Medicare reimbursement is lowered, I, like many other Clinical Social Workers, will simple not be financial able to provide services to the elderly and frail. Clinical Social Workers provide 41% of the nation s mental health services (CSWF, 2005) and are often the only mental health clinicians available to our nation s elderly.

I wish to also note that 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. The 14% proposed cuts
would make it impossible for me to cover my business expenses thus dictate that I stop providing services to the Medicare clients I presently treat.

I urge you to withdraw this proposed cut in reimbursement to LCSW mental health providers. It will have an extremely negative impact on the elderly and their ability to obtain quality mental health services.

In addition, I hope you will consider changing the inequitable reimbursement system that currently
exists, and implement equal pay for equal codes.

Sincerely,

Jill Gaumer, LCSW (DE) and LCSW-C (MD)

Submitter : Mrs. Abigail Grant **Date:** 08/20/2006

Organization : Mrs. Abigail Grant

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker, and Certified Clinical Social Worker in Gerontology in Cleveland, Ohio and a member of the Clinical Social Work Association. I have worked with my area's elderly and chronically ill population since 1983. I am writing to comment on the proposed CMS cuts to Clinical Social Workers, who provide 41% of the nation's mental health services, and are often the only mental health clinicians available to our nation's elderly and disabled. I am concerned about the impact these cuts will have on my ability to continue to provide services to Medicare enrollees; who make up the majority of my practice. In addition to office visits, I also see Medicare recipients who are confined to their homes and have no other access to mental health services.

While I see most Medicare enrollees under Current Procedural Terminology (CPT) Code 90801 and 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, decreases my ability to cover business and living 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.

Abigail Grant, MSW, LISW, CSW-G

Submitter : Ms. Sherry Sutherland **Date:** 08/20/2006

Organization : Ms. Sherry Sutherland

Category : Health Care Professional or Association

Issue Areas/Comments

Practice Expense

Practice Expense

August 20, 2006

RE: File Code CMS-1512-PN

Dear Sir or Madam:

I am a Licensed Clinical Social Worker in Virginia. I am writing to comment on the proposed CMS cuts to reimbursement rates as proposed in CMS-1512-PN. Clinical Social Workers provide the majority of mental health treatment services across the nation. Committed to those is greatest need, we strive to maintain a high calibre of service in the face of rising costs and eroding income.

With this planned reduction in reimbursement, I am concerned about the impact of these proposed cuts on my ability to continue to provide services to Medicare enrollees. The proposed 14% cut in reimbursement would make it impossible for me to cover my business expenses, which are already reimbursed at a level 25% lower than the rate of psychologists for the same procedure code.

I urge you to withdraw these proposed cuts in reimbursement to LCSW mental health providers, and to consider changing the inequitable system that currently exists,so that a new system can be put in place that establishes equal pay for equal codes across mental health practitioner disciplines.

Reducing compensation to those who provide mental health treatment to an ever increasing older and disabled population will set up a situation where only those Medicare patients who are able to pay out of pocket will receive needed services. Surely, this is not what the founders of the Medicare program intended.

Please rethink the current proposal, so that I and many others will be able to continue to provide much needed quality mental health services to Medicare recipients.

Sincerely,

Sherry Sutherland, MSW, LCSW
200 Little Falls St., Suite 205
Falls Church, VA 22046

CC: VA Senators and Representatives

Submitter : Dr. Robert Adler **Date:** 08/20/2006

Organization : Dr. Robert Adler

Category : Physician

Issue Areas/Comments

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

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

Re: Bone Mineral Density determination by DXA.
I work for the Dept of Veterans Affairs, so even though I read DXAs, I am not really affected by the plan to decrease reimbursement for it. For those of us who see fracture from osteoporosis as a major preventable health problem, DXA has been an excellent tool. It predicts fracture as well as blood pressure predicts stroke. But it must be done correctly. With over 10 years experience with the technique (and with >30 years of medical experience overall), I feel qualified to say that it takes more knowledge and judgment to read a DXA properly than a routine chest x-ray or abdominal film. Indeed, physicians look to the DXA for more than a reading in the abstract. The interpretation must be made in the context of the patient. For example, a bone density reading in a patient on prednisone might lead to therapy, but the same reading in a patient not on prednisone would not. The age of the patient, the history of previous fractures, and many other factors must be weighed when giving a final recommendation.
In the readings of DXA I provide for veterans, I give a diagnosis and a series of suggestions for further diagnostic procedures and for management. For the busy primary care provider who ordered the DXA, these recommendations save time, effort, and money because they are based on my expertise in osteoporosis. For example, I recommend that the patients who need the most help be referred to an Osteoporosis Clinic that I run. Thus, I make work for myself by doing this, and I get no extra rewards for doing so - other than that of doing what is right for the veteran population that I serve. But to make these recommendations takes my experience, my expertise, and my continued scholarship in keeping up-to-date in a rapidly changing field.
DXA is not a routine procedure, even though it is safe and non-invasive. It should be looked at in a way similar to some of the invasive radiologic procedures because an expert, with increased training is necessary to do it right. And doing the reading correctly leads to better medical care and appropriate use of resources. There are studies to show that when osteoporosis is diagnosed correctly and treated properly, not only are lives saved - but money too. Indeed, most people don't realize that the in our aging population, hip fracture increases mortality substantially. For those who survive, many end up in long term care facilities. By diagnosing osteoporosis and preventing fracture, fewer people will die and fewer will need nursing homes. Please consider DXA to be a complex procedure - safe and non-invasive - but requiring more than minimal skills to do correctly.

Submitter : Mr. Jeremy Fulwiler **Date:** 08/20/2006

Organization : Adelphi University

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

I am writing this comment in response to CMS-1512-PN. As a student in a masters of social work program at Adelphi University, I am very disconcerted with the proposed cuts in percentage for service reimbursement to social workers proposed in 2007 and again in 2010. The field of social work is uniquely poised to provide a deeply psychological view of an individual set in a dynamic context of social welfare. Cuts in reimbursement discourage the service providers and others considering entry into this important profession, particularly around such an important social service as Medicare. Please do not make these proposed cuts. Furthermore, when conditions allow, please raise rates in service professions in a way that is considerate of all service professions, not simply raising the rates for codes that favor the work of physicians. Service providers work together as a team - please honor and respect all of the positions in the field. Sincerely, Jeremy Fulwiler, Pawling, NY

Submitter : **Mr. joseph James** **Date: 08/20/2006**

Organization : **Mr. joseph James**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

see attachemnt

CMS-1512-PN-1991-Attach-1.PDF

CMS-1512-PN-1991-Attach-2.PDF

Attach #
1991

Joseph R. James, LCSW-C
8422 Bellona Lane, Suite 207, Towson, Maryland 21204
(410) 825-6925 JKWM@aol.com

To: (CMS) Centers for Medicare and Medicaid Services

Subject: Proposed 14% Fee Reduction

RE: CMS-1512-PN

1. The CMS proposed 14 percent reduction of the Medicare reimbursement rate will motivate me to:
   a. Stop treating Medicare patients.
   b. Stop treating TRICARE beneficiaries because their fee schedule is 80% of the CMS fee schedule.
2. **Rationale**:
   a. CMS is obviously copying rates established by the major mental health managed care companies who routinely take 45% to 63% for overhead, profit, acquisitions, etc. (CMS overhead is 3%.)
   b. I have been a practicing clinical social worker for 32 years. I can clearly remember being paid more for an hour of psychotherapy 28 years ago than what we are now paid.
   c. A good mental health and substance abuse plan requires **competent and experienced professional providers.**
      1) Reducing private practitioner's fees is self-defeating and a false economy.
      2) Low fees will turn the profession of clinical social work into a **volunteer charity** affordable only to people subsidized by a spouse's income or an inheritance or retirement from another job.
      3) Good therapists will not accept lower fees.
      4) You will be left with the least experienced, least competent practitioners treating the most difficult cases.
      5) New people will be discouraged from coming into the field.
      6) Because the overhead expenses of a clinical social worker in private practice will remain the same, **every dollar of fee reduction will represent about two dollars less in taxable income.**
      7) Remember that as **independent contractors,** CSWs **pay their entire overhead- rent, utilities, supplies, continuing education – as well as 100% of Social Security. Any benefits they take from health care to disability insurance or retirement come out of their taxable income. CSWs also work 2 hours for every paid hour.**
         - For example, for a CSW at $90 per hour has a taxable income of about $75,000 per year.
         - At $55 per hour taxable income drops to about $30,000 per year
         - **At $45 per hour taxable income drops to about $16,000 per year**
         - Again taxable income does not include any benefits like health insurance while at the same time 100% of social security comes from that amount.
      8) With the dramatic Draconian fee cuts by Managed Care, the practice of psychotherapy has been **changed from a cottage industry to a sweatshop** where the psychotherapists are piece laborers.
      9) **The impact of these fee cuts is that client recovery rates drop dramatically, requiring additional and more expensive future treatment while the cost of comorbidity mounts on the medical side.** (Wrich, Rationale for Providing Mental Health and Chemical Dependency Treatment Services to State of Maryland Uninsured Citizens, 2001)

d. **Comorbidity**: Morbidity means something causing a disease. Comorbidity means a disease has more than one cause.
    1) For each medical case there is a **40 to 60% chance that a behavioral health problem is an underlying factor in a physical disease.**
    2) For example, think of the impact of depression on heart disease. Think of the impact of alcoholism on diabetes. Think of the stress impact of an alcoholic spouse on the non-drinking spouse's depression or anxiety. (James T. Wrich, Brief Summary of Audit Findings of Managed Behavioral Health Care Services Submitted to the Congressional Budget Office; October 2000)
    3) A second serious problem with this division is that behavioral health problems **frequently go inappropriately treated or undiagnosed** by the Medical/Surgical component. 37% to 86% of audited managed care cases had clinical and administrative problems that were potentially jeopardizing to the patient. (Wrich, Ibid, 2000.)

e. We are **independent contractors** – we work for ourselves – like truckers, baseball players, musicians, and members of the Screen Actors Guild. Unlike them, we cannot collectively bargain at this time because **we are not exempt from anti-trust laws.** We can negotiate with CMS and managed care organizations but it is generally fruitless.

Even though Managed Care has **a monopoly on the DISTRIBUTION of our product** and sets the fees and terms under which we are allowed to practice our profession, we have not been able to negotiate any of these issues with it.

3. **Related Issues**:
    a. Equal Pay for Equal Work: All licensed therapists who do the same work should be compensated at the same level or the difference based on academic credential should be minimal. We all go to the same CHE training.
    b. All Ph.D.'s, whether in nursing, psychology, social work, marriage and the family, etc. should be paid the same.
4. **Summary**: Older citizens have more health problems with greater comorbidity incidence levels. Strengthening mental health treatment reduces medical treatment costs. Weakening mental health treatment through the proposed 14% reimbursement cut is cost ineffective. Mental Health professionals already are more severely victimized by managed care than are medical professionals. We are in an oligopoly, i.e. a market monopoly where a few producers of health services control the demand from many buyers. And we are powerless, stuck in the middle and forbidden by law to negotiate (unionize) as a group for living wage compensation.
5. **Requests**:
    a. That CMS not reduce work values by 7% for clinical social workers effective January 1, 2007;
    b. That CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and
    c. That CMS not approve the proposed "Top down" formula to calculate practice expense. Select a formula that does not create a negative impact for mental health providers.
    d. That CMS lobby the President and the Congress to move money from the DOD budget and tax breaks for millionaires so that improved funding occurs for healthcare. Also, provide Medicare for Everyone (Single Payer System) and save BILLIONS.

Joseph R. James, LCSW-C
Maryland License: 02748
Medicare Nr: Q468

Submitter : **Ms. Diana Berman** **Date: 08/20/2006**

Organization : **Ms. Diana Berman**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

August 20, 2006

TO: Center for Medicare and Medicaid Services
RE: Proposed fee reduction for Clinical Social Workers
File Code CMS-1512-PN

I am writing as a licensed Clinical Social worker, practicing in the state of Georgia, to express concerns over the proposed fee reductions for providing my services to Medicare recipients.

As a social worker, I evaluate and treat clients on a regular basis. I have over 20 years of experience as a practitioner. I am concerned that my services will now be reimbursed at a lower level.
1. My capabilities (work value) have not decreased. (The initial 7% percent decrease proposed concerns work value). On the contrary, every year I am more experienced, have trained to obtain more knowledge, and perform at a higher level of expertise. Why would the CMS decide to pay me less?
2. I am concerned that if fee reimbursements are decreased, experienced social workers will opt out of the Medicare program. This will leave only the more inexperienced social workers to work with some of the most challenging cases (in my experience).
3. I am also confused why the practice expense reimbursement would be decreased (initially by 2% and then by 5% by 2010). My expenses as a Clinical Social Worker have not gone down over the past 20 years. They rise regularly as do all expenses. For example, every year I get training to work even more effectively with my patients. That expense has not decreased or stayed stable over 20 years. It is my understanding that social workers are some of the lower paid mental health professionals (as compared to psychologists, MD s) and therefore we provide very efficient treatment options for people. We are both effective and efficient.
4. Most of my work is treatment not evaluation or management . Once I have performed an evaluation, I treat my patients and therefore get reimbursed under those codes that CMS is proposing to reduce. Without treatment, evaluation and management is useless. I agree that both those functions are important but treatment is equally important.

Please recognize that the treatment provided by Clinical Social Workers is invaluable to the mental health and, therefore, the functioning of many Americans. I request that CMS reconsider lowering the reimbursement levels for Clinical Social workers at this time.

Sincerely,
Diana Evans Berman, MSW, LCSW
14 Eastbrook Bend
Peachtree City, GA 30269
(770) 487-2289

Submitter : **Dr. Stephen Falk** **Date: 08/20/2006**

Organization : **Bay Area Obstetrics and Gynecology**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments-Gynecology, Urology, Pain Medicine

Discussion of Comments- Gynecology, Urology, Pain Medicine

In regards to the 80% reduction in the technical portion of reimbursment, and a 50% reduction in the professional component for DXA of the axial skeleton (CPT 76075): Currently the reimbursement is 140.00 and will now be reduced to 38.00. The 38.00 reimbursment does not even cover the cost for maintenance or upgrading of the equipment much less the cost for personnel to perform and interpret the test.

Submitter : **Ms. Marilyn Hocking** **Date: 08/20/2006**

Organization : **Marilyn D. Hocking, LCSW**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

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

August 20, 2006

Re: File Code CMS-1512-PN

Dear Sir or Madam:

As a Licensed Certified Clinical Social Worker in Virginia, I am appalled at the proposed 10-14% reimbursement cuts for clinical social workers and other primarily non-medical practitioners. While these cuts will also adversely affect physicians and their ability to meet expenses, those of us who are charged with providing similar services at only a percentage of the physician rate (already an inequitable situation) would be devastated. The current allowed rate for outpatient psychotherapy has not kept pace with inflation and already is significantly below what it should be. Reducing compensation further to those who render vital mental health treatment to an ever increasing older and disabled population would shake the necessary supports to provide basic services.

There seems to be a widespread misconception that health care professionals are extracting exorbitant fees for their services, and that this is the cause of so-called medical inflation. Like many other clinical social workers, I have not increased my (full) fee in at least six years, while the U.S. inflation rate has been 14.53%. At present Medicare pays only 50% of what they allow and requires the patient to pay the other 50% (currently $36.11). For the majority of my Medicare patients, this co-pay is impossible to meet on their fixed incomes and is often uncollectible. This is an undue hardship for my patients and for me. I struggle now to pay overhead expenses with less income per client and have to limit the number of Medicare patients in my caseload. As a small business person, I have no benefits or matching retirement funds to count on to help offset this drop in income. As the population ages I will be put out of business and patient needs will not be met.

As a person who subscribes to the Code of Ethics of my Social Work Profession, I have felt compelled to serve those who are unable to pay the full fee, and therefore have remained a Medicare provider all of these years. However, if the CMS reduces the allowed benefit 10-14% further, I shall no longer be able to serve Medicare clients. Many practitioners will be in this same situation; only those large entities with other sources of financial support (state funds, research grants, etc.) will be able to serve the ever-growing population of Medicare clients.

This is already a problem when trying to find psychiatric (medication) treatment for clients. Even though a psychiatrist can charge 30% more than a Licensed Clinical Social Worker for an evaluation or therapy session (according to the odd Medicare formula), many psychiatrists find this too low a fee to support the operation of their practice, and do not accept Medicare clients.

Where will these Medicare clients go for treatment? To already underfunded and struggling public programs? These programs stay afloat (barely) by employing less experienced, less educated staff to provide less individuated care at low salary. There are already long waiting periods for such programs, especially for chemical dependency treatment services. There is no consideration for the patient s choice of therapist in these programs. Those who earn an income above the designated percentage of the poverty rate are usually declared ineligible to access these programs. I have patients who have no income other than social security benefits who do not qualify as "low income." Thus, Medicare recipients who are ineligible or financially independent may have to pay out of pocket for their treatment needs, at a much higher rate, in order to access well-qualified professionals in a timely fashion.

This situation is hardly what the wise people who created the Medicare program envisioned. Please rethink these proposals, so that I and many others will be able to provide quality mental health and substance abuse

Submitter : Dr. Walid Gellad **Date:** 08/20/2006

Organization : Dr. Walid Gellad

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I strongly agree with both the ACP (American College of Physicians) and SGIM (Society of General Internal Medicine), that these changes in evaluation and management service payments are critical to the survival of primary care. Primary care physicians and internists are the primary players, in addition to patients, in improving quality of care and patient safety, and controlling costs. High levels of medical student debt and the inquality in payment for evaluation/management services are definitely contributing to the significant crisis in primary care. These proposed changes go a long way to correcting these problems.

Submitter : **Mr. Thomas Kascak** **Date: 08/20/2006**

Organization : **Physical Therapist**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1512-PN-1996-Attach-1.DOC

Attach 11
1996

8-20-06

Dear CMS:

I am a Physical Therapist with Hospital, SNF, and Out-Patient experience. I am principal owner of an out-patient faculty-based practice associated with Sacred Heart University and its Doctoral Program in Physical Therapy. I am primarily a clinician with a specialty in Upper Extremity care, having passed a National Certification Process to be designated as a Certified Hand Therapist (CHT). I also teach in the Doctoral PT Program enthusiastically sharing my 31 years of experience.

I am writing to strongly urge you to avoid making the severe Medicare payment cuts in 2007 to Physical Therapists and other health care providers as proposed in the June 29th 2006 fee schedule. It is already a hardship for many caregivers to provide services to this population. These elderly individuals require more time and effort to treat than younger clients with the same diagnosis. This mostly occurs due to co-morbidities and deteriorating cognitive status. My facility continues to treat this clientele having more referrals from physicians who chose NOT to have these patients seen at the doctor's own(ed) practice. Thus, there are already a decreasing number of providers for this patient population and severe reimbursement cuts will likely restrict the provider population even more. I know for a fact that other therapists are choosing to avoid participation with Medicare patients because they can not survive with the low reimbursement schedule. Granted, we are in Fairfield County CT and the lease or ownership costs are high, but I'm beginning to hear this from colleagues across the country as well. This result is exactly opposite the stated goals of the Medicare payment system to preserve patient access and achieve greater quality of life.

Please consider avoiding cuts altogether but if cuts must be made, at least phase them in and allow the time to assess the impact to the clients you are proposing to serve.

Thank you very much for your consideration of my comments and the many others I am sure you are receiving.

Respectfully,

Thomas Kascak, PT, MBA, CHT
Director, Sacred Heart University Rehabilitation
Pitt Health and Recreation Center
5151 Park Avenue
Fairfield, CT

Submitter : **Ms. Janet Cramer** **Date: 08/20/2006**

Organization : **Cramer Marriage and Family Therapy**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Janet F. Cramer, MS. LICSW
Cramer Marriage and Family Therapy
14 Park Place, Suite 3, Brattleboro, VT 05301
Tel: 802-254-5500, fax: 802-258-3926

August 19, 2006

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

To Whom It May Concern:

I am a 70 year- old clinical social worker, still providing services to elders and their families, both in my office and in their homes. I am writing to protest the proposed change in the Medicare Physician Fee Schedule, RVU (work) and the Practice Expense Values, which would result in a 9 percent reduction in reimbursement for my social work services, effective January 1, 2007 and possibly a total reduction of 14% by 2010.

Already mental health care is burdened by Medicare B s requirement of 50% copayment from the client, rather than their 20% copayment for physical health services. Now you are proposing to further limit the care available to elders and disabled individuals by making it financially impossible for clinicians like me to provide care outside of my office. If I want to be able to cover my office expenses I will need to limit the number of clients I take under Medicare and Medicaid if. (As the former Board President of the local Area Health Education Center I have made a point of taking Medicaid clients, who often tell me how hard it is for them to get mental health care.)

The proposed 10 % increase in the evaluation and management codes, generally restricted to physician use, and unavailable to clinical social workers, is especially inadvisable in the light of the proposed cuts for the people providing direct service to elders. Physicians do not have the time to provide the consistent care and personal attention that depressed, anxious and ill elders need for their emotional distress. Indeed, there was much attention to developing physician extenders during the seven years I was employed by the Veterans Administration Medical Center in White River Junction, VT. Please wait to implement the increases for physicians until there are enough funds to increase reimbursement for all Medicare providers.

Finally, these cuts affect my family personally. My retired Episcopal priest husband has struggled for years with chronic, intractable depression. I fear these cuts will add to his personal distress if the skilled providers he relies on will no longer be willing to treat him.

Very truly yours,

Janet F. Cramer, MS, LICSW

Practice Expense

Practice Expense

Please do not approve the proposed "bottom up" formula to calculate practice expense. Instead, I request you select a formula that does not create a negive impact for clinical social workers who have very little practice expense as providers, other than the constrictions of their time and energy in providing needed service.

Submitter : Dr. David Cavagnaro **Date:** 08/20/2006

Organization : private practice

Category : Physician

Issue Areas/Comments

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

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

I am writing to express my serious concerns about the proposed cuts in reimbursement for DXA (DPT code 76075) and VFA (CPT code 76077), proposed as part of a5-year review of the Medicare Physician Fee Schedule.

I'd like to begin by saying that as an internist, I see the recent advent of good medications to effectively treat osteoporosis as a major step in my ability to actually impact the quality of life of my elderly patients. Earlier in my career, osteoporosis was something we just more or less avoided because there was not much we could do about it. We would watch helplessly as multitudes of our patient developed severe, painful, and expensive fractures, mostly to the hip and spine. Now we have the technology to diagnose those at risk of fracture and evaluate the effectiveness of our treatment of their osteoporosis This has given great satisfaction to me as a physician, and I think it is going to result in a major future reduction in healthcare costs, as we have to deal with less fracures anongst the elderly. with their major cost for hospitalization and surgery, not to mention the costs associated with the medical complications associated with fractures.

The proposed reimbursement cuts are going to greatly reduce the access of our patients to DXA and VFA scanning and its attendant benefits. Long-run savings in Medicare dollars are going to be lost. Currently these procedures are relatively inexpensive and available to patints even in the office of some primary care physicians such as myself

I think a significant issue is that somme of the assumptions used to recalculate the Medicate Physician Fee Schedule were inaccurate. The expense to provide good scanning is greatly underestimated. Many physicians such as myself have gone to great educational expense to become certified in reading and interpreting DXA and VFA scans and expert in the treatment of osteoporosis. Moreover, newer state-of-the-art equipment costs about twice as much as CMS calculated because CMS based its calculations on the older pencil beam technology, now rarely used, instead of the newer fan beam technology use by myself and most of my colleagues. I recently upgraded to a new fan beam unit. Further the cost of paying a well-trained, skilled technologist to perform the tests is significant.

I urge you not to enact these proposed fee cuts, which I think will make it impossible for some physicians, such a myself, to continue to provide this service. This in turn is going to result in a substantial loss in Medicare savings to future generations as we perpetuate the underevaluation and undertreatment of this devastating and costly disease.

Sincerely,

David J. Cavagnaro, M.D.

Submitter : **Dr. Puthugramam Natrajan** **Date: 08/20/2006**

Organization : **Reproductive Endocrinology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam,

Re: CMS_1512-PN, RIN 0938-AO12
I would like to discuss about the changes in the Reimbursement of DXA scans for Osteoporosis.
I take care of large number of menopausal patients and have been doing DXA scans on these women to protect them from getting Osteoporosis, Fractures etc.
I sincerely hope this benefit is not taken away from them.
The technique we are using the Fan beam and not pencil beam which is lot more expensive for us.
Please do consider this in your decision making.
Sincerely,
Dr. P.Natrajan M.D.FACOG,CCD.
706-724-8878
903,15th street,
Augusta,
Ga 30901.

Submitter : Mrs. Diane Palmer **Date:** 08/20/2006

Organization : Enterprise Counseling LLC

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

The proposed fee cut for clinical social workers would have a severe impact on my counseling practice. I specialize in working with seniors and for many offer home visits. This already takes me time that I am not paid for which reduces the number of clients I can see in a day. Cutting the fee would add an additional burden. There are so many professionals who prefer not to provide services to seniors as it is. This would be an additional reason for professionals to refuse to serve our senrio population. With depression and anxiety disorders so prevalant in this population, and a known factor for medical and ER use- decreasing mental health services may increase medical cost.

Submitter : Dr. Jeffrey Carstens **Date:** 08/20/2006

Organization : Nebraska Heart Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-2001-Attach-1.DOC

Attach #
2001

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

08/18/2006

Dear Dr. McClellan:

On behalf of Nebraska Heart Institute and our 33 individual practicing physicians, 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.

Nebraska Heart Institute has seven offices across the state, including four outpatient cath labs in Lincoln, Omaha, Hastings, and North Platte, Nebraska. Before Nebraska Heart Institute's cath labs in Hastings and North Platte were installed, patients had to travel hours to receive elective outpatient catheterizations, and our labs in those relatively rural areas have significantly improved patient care and access to proper diagnostic testing for suspected coronary artery disease. We perform 3,000 heart catheterizations in these four labs 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") 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.

Because the cost data for catheterizations in particular do not reflect the actual cost of providing heart catheterizations, we may be forced to close our four Nebraska catheterization labs, as we would be losing money on every single procedure. This would move 3,000 elective catheterizations to other Nebraska hospitals, which would still be able to cover the cost of doing a catheterization. We believe this would cause a serious patient access problem for patients needing emergent catheterization in a hospital setting. Door-to-Balloon Time, an important measure of the survival of acute cardiac patients, would most certainly increase due to the large numbers of elective procedures in hospital labs. We believe that shifting elective catheterizations with low complication rates to hospital labs would create an inability to provide the high-quality care Nebraska's hospital patients currently receive.

Sincerely,

Jeffrey S. Carstens, MD