Submitter : Dr. Ed Lowenstein **Date:** 08/20/2006

Organization : Dr. Ed Lowenstein

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

Dear Sir:
I wish to inform you that the 14 percent reimbursement cut for services provided by clinical social workers will affect my practice and result in my withdrawal as a Medicare provider. I believe I reflect the reaction of many private practice social workers who are medicare providers. I urge you not to reduce work values of clinical social workers which are supposed to be effective on January 1, 2007. Increasingly, medicare clients will rely on social work services to deal with their mental health needs but also to support the proper and effective use of medical services by these medicare recepients. Anything that reduces the availability of clinical social work services will be a disservice to current and future medicare recepients. For this reason I am also requesting the withdrawal of the proposed increase in evaluation and management codes and request until there are more funds for all providers. Also, I urge the CMS not approve the proposed "bottom up" formual to calculate practice expense. Clinical social workers have little practice expense as providers and the proposed recommendations will prove negative not just to them and their willingness to participate in medicare but ultimately to medicare recepients who will loose the availability of well trained professionals.

Thank you for your consideration.

Ed Lowenstein

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

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in North 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 nation's mental health
services (CSWF, 2005), are often the only mental health clinicians available to our nation's elderly. I am concerned about the impact these cuts will have on my ability to continue to provide services to Medicare enrollees.
While I see most Medicare enrollees under Current Procedural Terminology (CPT) Code 90806, I am reimbursed at a level that is 25% lower than the rate for psychologists for the same codes. This has always seemed unfair, since the same codes mean the same kinds of services are being provided. However, lowering the reimbursement rates further, as the 14% proposed cuts would, would make it impossible for me to cover my business expenses and, therefore, would make it difficult to continue serving the Medicare enrollees I currently treat.
I would appreciate your withdrawing the current proposed cuts in
reimbursement to LCSW mental health providers. In addition, I hope you will consider changing the inequitable reimbursement system that currently exists, and implement equal pay for equal codes.
Louise W. Coggins, MSW, LCSW, BCSW, ACSW.

Submitter : Linnea Goddess **Date:** 08/20/2006

Organization : Linnea Goddess

Category : Health Care Provider/Association

Issue Areas/Comments

Practice Expense

Practice Expense

I am a licensed clinical social worker and part owner of a multi-disciplinary mental health practice in Delaware. I am writing to voice a strong objection to any efforts being proposed to lower the reimbursement rates for clinical social workers when they treat Medicare clients. During the 17 years that I have been in practice, I have seen an increasing number of practioners refusing to participate in any third party payer system, be it insurance companies, Medicaid or Medicare because of time consuming, inequitable procedures and low reimbursement rates. Fewer and fewer practioners are willing to work on any but a fee for service basis. If you lower the reimbursements for services to Medicare clients, I can assure you that will result in fewer clinical social workers available to service Medicare recipients' mental health needs.

Submitter : Ms. Judi Travis **Date:** 08/20/2006

Organization : Ms. Judi Travis

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am strongly opposing the suggestion of a 7 percent reduction in work values and a 2 percent reduction in Practice Expense values effective January 1, 2007 for social workers. The total reduction in reimbursement is expected to be 14 percent by 2010 for clinical social workers--one of the highest reductions of all covered professions. This is going to make it impossible for me to continue to treat Medicare patients and I will have to deny services to them as my practice expenses continue to rise. Medicare patients will find it difficult to find willing providers if fees are cut.

Submitter : Gail Davidoff **Date:** 08/20/2006

Organization : Private Practice

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker (LCSW) and a member of the Clinical Social Work Association. I am writing to comment on the proposed CMS rate cuts. Clincial Social Workers provide at least 41% of the mental health services in the US. We are often the only providers in many underserved areas.
I am concerned about the impact of these proposed cuts will have on my ability to continue to provide services through Medicare to our nation's elderly. While I, as well as all social workers, see clients using the CPT code of 90806 I am paid at a level that is 25% less than that of psychologists though the US Supreme Court has recognized that LCSW serices are equal to those of psychologists. While this discrepancy has always seemed unfair, it would be impossible for me to cover my operating expenses should the new regulations go into effect since they will reduce reimbursement another 14%. In summary, I would need to discontinue providing service through Medicare should this change occur.
I would appreciate your withdrawing the current proposed cuts in reimbursements to LCSW as well as consider the inqequities that already exist.

Submitter : **Catherine Courtney** **Date: 08/20/2006**

Organization : **NASW**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

cut in services would greatly harm my practice as well as my patients. Please do not reduce work values for clinical social workers. Please withdraw the proposed increase in evaluation and management codes until the funds are available to increase reimbursement for all Medicare providers. Please do not approve the proposed bottom up formula to calculate practice expense and instead select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Sincerely yours,
Catherine M. Courtney, LCSW, RN

Submitter : Dr. Scott Klein **Date:** 08/20/2006

Organization : North Dakota Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

To Whom it may concern:

As a practicing board certified Anesthesiologist in the Midwestern United States it disturbes me to have to address a problem concerning medicare reimbursement and the proposal to further reduce payments for anesthesia services. In the proposal cited above anesthesia providers would face immediate payment reductions of SIX PER CENT and at five years realize a TEN PER CENT payment reduction. This to cover overhead for a limited number of services in other specialities.

Anesthesia historically has been an undervalued service. Despite this inequity the CMS has targeted the speciality of Anesthesia for further payment reductions. At this time I must protest as the continued erosion of payments to providers of Anesthesia will most certainly result in a loss of services to those fragile elderly persons who are in greatest need of medical care.

The AMA and others have petitioned for a study to gather updated information on actual work data to provide a more accurate basis for proposed alterations to the Physician Fee Schedule. I support such an undertaking prior to implementing any changes. I believe the historical data is inaccurate and will lead to a flawed conclusion perpetuating further errant reductions in the fee schedule for Anesthesia.

Anesthesia is an adjunctive service which is reliant on other providers for patient referrals. Our payor mix in this region is more and more reflecting our country's aging human population. Our medical centers' bottom line is likewise adversely effected. As one of only four major medical centers to serve our entire state one can imagine that changes to any already undervalued payment schedule should reflect accurate data so as not to jepardize an already tenuous financial standing.

I respectfully request your earnest consideration of these concerns in reviewing the proposal prior to implementing changes to the Medicare Physician Fee Schedule.

Scott Klein, MD

Bismarck, North Dakota

Submitter : Dr. Mark Knouse **Date:** 08/20/2006

Organization : Lehigh Valley Hospital

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

Sirs: Please strongly consider adopting the proposed increase in work RVU for EM codes as recently proposed. It would be favorable to maintain budget neutrality by using a conversion factor rather that a 10% decrease. I am a practicing Infectious Diseases specialist and find that I am working many more hours over the last one to two years and not even "staying even" The current EM codes do not allow full time Internists to come close to their "true value" Neutrality is important, as our group has an exhaustive practice outpacing almost all others in our institution to keep the the current patient population in sound health with excellent ID consultations. I strongly encourage CMS to adopt the recommendations of the AMA's RVU update committee. Thanks so much (we need help)
Mark C. Knouse MD FACP

Submitter : **Ms. Andrea Caudle** **Date: 08/20/2006**

Organization : **Psychotherapist**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

I am writing to state that the 14 percent reimbursement cut will affect my private practice significantly to the point that I may not be able to continue to provide treatment to my patients with Medicare. Please withdraw the proposed increase in evaluation and management codes until funds to increase reimbursement for all Medicare providers. Also, please do not approve the proposed "bottom up" formula to calculate practice expense. I am requesting that CMS select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

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

Organization : Redding Family Medical Group

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 a Family Physician and have been in practice in Redding, Ca. for 26 years. Each year since I started practice the ability to give cost effective, quality medical care has become more difficult. The proposed changes to the reimbursement for DXA scans for osteoporosis screening will in my opinion result in fewer men and women being screened for this disease. At a time when the surgeon general criticizes physicians for not being aggressive enough in screening and treatment of bone related diseases, it seems short sighted to put additional roadblocks to appropriate screening by primary care physicians. By lowering the reimbursement for a DXA scan you will make the total cost of performing a quality scan (tech time, lease or cost of machine, rental space for the machine, utilities, tech training, machine maintenance, and supplies) above a break even proposition for the average Family Physician. Family Medicine Physicians aren't looking for another 'loss leader' as they attempt to provide comprehensive, quality preventative health care. Fewer Family Physicians will be able to offer convenient in-office testing. The current cost of owning a fan beam machine is now at least $65,000.

The cost of preventing ostoeporosis and the resultant fractures caused by this disease would be far outweighed by the eventual increase in costs to the Medicare program by even a small increase in hospitalizations for these fractures.

Please reconsider the issue of reimbursement for DXA Scans of the axial spine (CPT 76075). A further reduction in reimbursement will result in higher long term costs and a decrease in quality preventative care for a treatable disease.

Thank you.

David W. Civalier, MD

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

Organization : Ms. Janet Robbins

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

To Whom It May Concern:
I strongly oppose the proposed reduction of both the Work Values and Practice Expense of social workers proposed for 2007 and 2010.

Psychotherapy is a critical component to improving and maintaining both the mental and physical health of senior citizens. As the Medicare population increases, more patients have psychiatric illnesses, preexisting as well as newly diagnosed, which are complicated by more acute and chronic health conditions. Current research suggests that at least 25% of seniors will have significant mental health problems. These cuts will make it less likely that their needs will be addressed.

I have been a Medicare provider of psychotherapy for nearly six years where over time, I have found myself increasingly in the role of preventing not only costly inpatient psychiatric hospitalizations but also preventing costly medical tests, trips to emergency rooms and hospitalizations. Unlike most other disciplines or specialities, psychotherapists take time with patients. We take into account the whole person because medical health problems frequently cause or exacerbate mental health problems and vice versa. Often reinforcing a physicians plan of care, we encourage patients to follow medical instructions, increase their understanding of and adjustment to their conditions, and we play an important role in medication compliance. Physicians depend on our psychiatric assessments and preventive treatment of patients because they either do not have or take the time with their patients to explore mental health problems. Research has demonstrated that mental health affects illness, recovery and health maintenance; and the obvious corollary that psychotherapy promotes mental health (American Psychological Association).

Clinical Social Workers provide more psychotherapy to Medicare recepients than all other mental health discipline combined (National Association of Social Workers). By reducing our reimbursement, my experience as a leader in the Clinical Social Worker Medicare Provider Task Force in New Jersey is that fewer clinical social workers will elect to continue or become Medicare providers. As a result, the mental and physical health of Medicare beneficiaries will suffer; and more unnecessary hospitalizations will occur, consequently raising health care expenses.

Rather than punishing one aspect of health care (mental health) so disproportionatly while leaving other specialities nearly unscathed, I would recommend revamping the reimbursement system across the board. In the meantime, if any reductions must be made, make them uniform. Otherwise, the growing mental health needs of seniors will be untreated due to the shrinking pool of providers available to treat them.

Social work psychotherapists are among the most economical and productive of health care professionals. The National Association of Social Workers projects a critically low proportion social workers, moving to this work in the future. It is ironic that at a time when researchers in even the 'hard' biological sciences have come to recognize the vital role of mental health in healing, cuts would be proposed that ignore that connection.

Please do not hesitate to contact me if I can be of future assistance: (609) 466-1552.

Sincerely,
Janet E. Robbins, M.S.W., L.C.S.W., A.C.S.W.

Submitter : Ms. Deborah Schuster **Date:** 08/20/2006

Organization : Private Practice

Category : Social Worker

Issue Areas/Comments

Background

Background

A 14 percent reduction in fees would be devasting to my practice. It will also affect all Medicare recipients. Until now, medicare assignment afforded the elderly and disabled access to healthcare. Like the HMO's, practitioners will give up taking assignment in order to keep themselves financially solvent.

Submitter : Dr. GLENN TOVAR DIAS **Date:** 08/20/2006

Organization : Glenn A. Tovar Dias MD PA

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

Re: CMS-1512-PN, RIN 0938-AO12

I am a busy solo internist in Ft. Myers, FL.. My practice is approx. 70% Medicare. We employ 9 employees including a nurse practitioner.
Attempting to enhance our practice we invested in a current fan beam based technology DXA machine which cost us $56,000, knowing that the reimbursement was approx. $140 per scan.
We were stunned to hear the proposed reduction in reimbursement for the technical and professional component for DXA of the axial skeleton (CPT 76075).
How do we survive these proposed cuts and the loss we would take on the equipment and personnel? How can we ever invest in newer technologies and practice enhaqncement tools when the rules re reimbursement can change at any time? How do good internists and primary care physicians stay in practice with costs increasing and Medicare cutting reimbursement for office visits and office based tests. This at a time when in fact reimbursement should be increasing to attract more residents and physicians to the primary care arena.
These cuts will kill options for solo practitioners and small group practices to stay in buisness.. Who would you have your parents and your elderly loved ones see as their primary care physician? A physician employed by a big HMO or a large multispecialty organization where there is a frequent turnover of physicians or a physician who being invested in his practice and the community will be there to take care of them for the long term compassionately.
We know you have a shrinking budget with health care costs rising. But the most cost effective management of your resources is to attract quality physicians to primary care and providing them the tools to stay in practice. Hence please consider our desparate plea, when making your decisions. Thank you.

Submitter : Mrs. Sharon Chamberlain **Date:** 08/20/2006

Organization : WashingtonState Society of Clinical Social Work

Category : Health Care Provider/Association

Issue Areas/Comments

Practice Expense

Practice Expense

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

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

Submitter : Laurie Swift **Date:** 08/20/2006

Organization : Laurie Swift

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am a licensed clinical social worker in private practice who provides services to Medicare recipients. A 14% reimbursement cut would seriously affect my income, which is marginal already due to Medicare and managed care reimbursement rates which do not take into consideration my business expenses, cost of medical insurance, lack of sick days, vacation days, etc. A rate cut could influence me to stop accepting Medicare recipients in my practice, even though I would prefer to continue providing services to this population. Please do not reduce work values for social workers, and do withdraw the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Medicare providers. Please do not approve the proposed 'bottom up' formula to calculate practice expense. Instead please select a formula that does not create a negative impact for clinical social workers like myself.

Thank you for taking my needs and the needs of other service providers like myself into consideration. By doing so, you will also be serving the needs of Medicare recipients.

Submitter : **Ms. Sharon Payne** **Date: 08/20/2006**

Organization : **Ms. Sharon Payne**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

August 21, 2006

Dear Sir or Madam,

I am appalled at the proposed 10-14% Medicare reimbursement cuts for clinical social workers and other non-medical practitioners. Clinical social workers provide the majority of mental health services in the United States and work in many settings across the country with elderly and disabled persons who receive Medicare benefits. Good outpatient mental health benefits for any group of citizens have the benefit of helping those individuals maintain good physical health as well. Not only is this a quality of life benefit, it is also fiscally sound, a good investment.

I have been in practice since 1975 and have seen reimbursement for my services decline, while my expenses have increased. Between 2004 and 2005 alone, my expenses have increased 9%. There will likely be another increase this year. Medicare currently reimburses only 58% of my full fee. If that percentage is further decreased, I will not be able to afford to serve Medicare recipients.

Experienced mental health clinicians like me must be able to earn a living wage while providing services to those in need. Your proposed degradation of benefits for Medicare beneficiaries will have the impact of decreasing access of those individuals to good mental health care because many of us will be unable to afford to treat Medicare beneficiaries.

Please reconsider your proposed reimbursement cuts. They will have the consequence of denying access to good mental health care for Medicare beneficiaries. Public mental health services, the only option for these individuals are already strained beyond their ability to serve those without insurance. Please investigate what this cut would mean.

Sincerely yours,

Sharon L. Payne, LCSW CSAC
533 Newtown Road Suite 115
Virginia Beach, VA 23462
757-490-0725

Submitter : Ms. Nancy Code **Date:** 08/20/2006

Organization : Clinical Social Work Association

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

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

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

Submitter : Dr. Karam Bhalla **Date:** 08/20/2006

Organization : UNM

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing in order to support the recommended work RVU increases for evaluation and management services.

In the last 10 years, much complexity has been added to the overall medical system including vasts gain in technology that has considerably increased the physician's work load and amount of time required to spend with each patient.

For example, collecting the various imaging data and laboratory data such as X-rays, CT scans, and MRI's in order to assess a disease process such as multiple myeloma along with the lab data such as electrophoresis gel results takes considerable time to evaluate, process, and interpret for the patient and then to guide further mananagement. This work needs to be compensated accordingly and at present, fails to be even acknowledged. The current standards need to be reevaluated in light of the increase in overall increased work load that has occurred in the last ten years.

In order for physicians to continue the utmost care towards their patients I urge and give firm support for RVU increases for evaluation and management services. These changes will help assure continued access to primary care services.

Not doing so would certainly compromise patient care in light of the increasing informational data that a physician needs to work through in order to make the best possible decisions when it comes to patient care.

I urge and support the necessary RVU increases for E/M services as work load per patient has increased tremendously in the last ten years.

Submitter : Ms. Margot Aronson **Date:** 08/20/2006

Organization : Greater Washington Society for Clinical Social Wor

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Re: File Code CMS-1512-PN
As a clinical social worker, I emphatically oppose the reduction in rates which will make it more difficult for us to be able to afford to participate and in turn more difficult for the elderly and the disabled to find experienced clinicians.

Submitter : Ms. Harriet Copeland **Date:** 08/20/2006

Organization : Ms. Harriet Copeland

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

Fee for services to Social Workers should not be reduced, and if necessary fees for other services should not be increased if it necessitates this considered reduction.

Submitter : Mr. Richard Cohen **Date:** 08/20/2006

Organization : Mr. Richard Cohen

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

My comment concerns the proposed reduction in Medicare fees for Clinical Social Workers. Fees have already been reduced and practice expenses keep rising. LCSWs are the primary providers providing psychotherapy to Medicare recipients, they need to be treated and reimbursed fairly.
Thank you,
Richard M. Cohen, LCSW, BCD

Submitter : Dr. Gwendolyn Pla **Date:** 08/20/2006

Organization : Greater Washington Society for Clinical Social Wor

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

File code CMS 1512-pn.

I am a clinical social worker licensed in Maryland and in the District of Columbia. I reside in Montgomery County, Maryland. I strongly oppose the proposed reduction in fees for social workers for Medicare services. Currently, I am a participating provider in the Medicare program. A fee reduction will make it impossible for me to continue providing services to those in the population for whom these services are most needed. I am sure that many social workers will leave the program and the nation's elderly and disabled will have less access to these important services.

Submitter : **Ms. Joan Pedersen** **Date: 08/20/2006**

Organization : **private practitioner**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

File Code CMS-1512-PN

As a clinical social worker and Medicare provider, who specializes in psychotherapy for the geriatric population, I vehemently oppose the proposed reduction in Medicare rates. I know many colleagues, not to mention several mental health clinics in Montgomery County, who no longer accept Medicare patients, while others plan to do similarly. This change will only deny elderly and disabled patients the opportunity to receive competent mental health services. (Indeed, it is already difficult for many Medicare patients to find providers.) Should this rate reduction go into effect, I too may be forced to drop my participation in Medicare.

Thank you for this consideration.

Sincerely,

Joan Pedersen, LCSW-C
16013 Comprint Circle
Gaithersburg, MD 20877
301-527-1382

Submitter : Dr. Peter Kamilakis **Date:** 08/20/2006

Organization : Dr. Peter Kamilakis

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I am an anesthesiologist, and the proposed cuts in Medicare reimbursement for FY2007 are potentially devastating. For many years, anesthesia services have been undervalued by CMS, and I have serious concern that the data that CMS is using to estimate practice expenses is outdated and an underrepresentation of what it truly costs us to provide care to Medicare patients.
The MGMA is preparing a survey of current costs based on 2006 data, and this would be a much more accurate representation of practice expenses. Please do not continue to use the outdated methodologies to calculate the value of anesthesia work.
The requirement that changes in reimbursement should be budget neutral mandate that some specialties have to pay for the poor reimbursement given to other specialties, and we in anesthesia are being made to stretch ourselves thinner and thinner to provide consistent and quality care to the increasing Medicare rolls.

I see serious potential problems with access to care for medicare patients if the federal government continues to pay less and less for services that are increasing in cost to provide every year because of increasing federal regulations and constant concern about quality services. The participation of anesthesiologists in Medicare, like all physicians taking care of Medicare patients, is CRUCIAL for the health of our senior citizens. Please postpone the 6% cut for anesthesiology and other specialties until ACCURATE data can be obtained, and implement a positive payment update until the SGR formula can be reworked.

Thank you.

Submitter : Mr. Lawrence Lubertozzi **Date:** 08/20/2006

Organization : National Association of Social Workers

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

The proposed reimbursement rates cuts for clinical social workers are un reasonable and punitive.

Submitter : Ms. Carol Hart **Date:** 08/20/2006

Organization : Ms. Carol Hart

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-2027-Attach-1.DOC

Attach #
2027

291 Main Street
PO Box 29
Tilton, NH 03276

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

To Whom It May Concern:

I am a licensed clinical social worker and have just received notice of file code CMS-1412-PN, the proposed fee reduction for social workers who are Medicare providers, and reimbursement increase for evaluation and management codes, which in general will benefit physicians. I ask that you consider the ramifications of this proposal, withdraw both the suggested decreases for clinical social workers and increases for evaluation and management, until funds are available for equitable reimbursement to **all** providers.

I work as a private practitioner; and as such, the overhead expense of managing a full time office falls solely on me. Currently, it is my experience that Medicare rates are among the lowest in insurance reimbursement. Almost half of the clients on my caseload are Medicare recipients. Most of them have little income, are on disability, and are unable to pay the balance of what Medicare doesn't cover. A 14% decrease in fees over the next four years would have a significant impact on my income.

As a social worker, I am committed to serving people who are economically and socially marginalized in our communities. However, if this proposal goes through, it would clearly affect my willingness, and financial ability, to sustain a private practice or to take on Medicare clients.

Clinical Social Workers, whether we work in private or public practice environments, are on the front lines of direct service on a regular basis. We work with some of the most difficult and trying people in our communities, many of whom have long term mental health issues. We deserve to be compensated at least decently, if not well, for the work that we do.

CMS should be a leader in setting fee scales. Please withdraw this proposal, for it would do a disservice not only to clinical social workers, but also to the people we serve. Thank you for your attention to this matter.

Sincerely,

Carol Hart, LICSW

Submitter : Ms. Vicki Doueck **Date:** 08/20/2006

Organization : Generations-Counseling

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

I am referring to the reduction of reimbursement to Clinical Social Workers of 14% will affect my practice. I am one of the few clinical social workers who makes home visits to the elderly and homebound. My agency has been doing this since Medicare reimbursed social workers. I pay my employees for their travel time and for gas. I am barely able to cover costs now. If there is a fee reduction I doubt that I will be able to continue my practice. In addition, I have billing expenses, phone expenses and other expenses that will actually leave me with a loss. Social workers are the only professionals that make home visits. In addition we visit facilities and have expertise in the elderly. We service them in the most cost effective way. Clinical social workers are the least expensive way for the elderly to receive mental health services. I have no choice but to be a participating provider as other professionals do. Therefore I will not be able to even meet my own personal expenses. My whole practice is based on servicing the elderly and disabled. I am requesting that CMS not reduce work values for clinical social workers, withdraw the proposed increase in evaluation and management codes until you have unds to increase reimubrsement for all Medicare providers, not approved the proposed "bottom up" formula to calculate practice expense, and select a formula that does not create a negative impact on my practice and in the provision of services to the homebound and the elderly. As it is the fee has been reduced since 2005. I have had to lay off and not rehire any clinical social workers for 2006 because I could not even pay them a fair salary let alone benefits. This will severly impact my practice and others like myself

Submitter : Dr. John Mansell **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Lawrence Mason` **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Ms. Nancy Wolfson **Date:** 08/20/2006

Organization : Kensington Mental Health Association

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in Maryland and the District of Columbia in a private practice setting. I am writing to comment on the proposed cuts to reimbursement rates as proposed in CMS-1512-PN.
I emphatically oppose the reduction in rates. I am concerned about the impact these cuts will have on my ability to afford to provide services to Medicare enrollees and in turn make it more difficult for the elderly and the disabled to find experienced clinicians.

Submitter : Dr. James Mathers **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Dirk Hutchinson **Date:** 08/20/2006

Organization : Salina Clinic

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I am writing in support of the RUCs proposed E/M recommendations. I urge you to finalize the recommended work RVU increases for evaluation and management services. As an internist, my practice consists of 50% patients over the age of 65 and a large percentage approaching that age. As my patient population ages, the complexity and work associated with delivering good patient care continues to increase dramtically. Almost all of the visits from this population of patients involves the attention to multiple problems including diabetes, heart disease, arthritis, hypertension and hypercholesterolemia. This is in fact the profile of my typical patient. I saw a patient three days ago who came in for a routine follow-up visit. Her diabetes was out of control on three kinds of insulin and two pills, her diabetic peripheral neuropathy was not responding to the new medication that I had started at her last visit, she was having left knee pain suggestive of arthritis, further limiting her ability to walk, her blood pressure was not well controlled on three medications, she had gained weight and is already obese, she had developed and infected ingrown toenail, and her husband (caregiver) was extremely frustrated with her. They both required extensive counseling regarding her medications, had to be instructed on two new medications (carefully picked to avoid interference with her existing drugs), her knee X-ray was reviewed with further treatment recommended, her infected toenail was trimmed and exercise counseling was done in light of her knee, toe and neuropathy. This is not untypical of a visit from many of my patients. Because of concerns regarding undervaluing of my services for Medicare patients, I have stopped accepting any new Medicare patients and may be forced to ask my existing patients who are in their late 50s and early 60s to go elsewhere when they turn 65. Talking to my fellow internists, I beleive that undervalued evaluation and management services is rapidly becoming an access to primary care issue if nothing changes. I urge you to reject any comments that would lower the overall improvements in work RVUs for evluation and management services that have been proposed by the RUC.

Submitter : Dr. Edith Newsome **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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Submitter : Dr. Gary E.D. Oldenburg **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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

Submitter : Dr. John Scheub **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

See Attachment

CMS-1512-PN-2038-Attach-1.DOC

Attach # 2038

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SPINE AND SPORTS
REHABILITATION CENTER

PHYSICAL THERAPY

August 21, 2006

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Dear Sir/Madam,

I am writing to express my opposition to the revisions to the work relative value units (RVU's) and the methodology for calculating practice expenses RVU's. These revisions will serve to dramatically cut the rates of the physical therapy fee schedule and will impact the ability of PT clinics to deliver quality care to their patients. I am a licensed physical therapist and a co-owner of an outpatient orthopedic practice located in Baltimore, Maryland. Our practice has been providing quality physical therapy service to the community for 14 years. We not only pride ourselves on delivering outstanding care to our patients, but also on our strict compliance with lawful and ethical use of CPT codes in our billing practices.

According to the Medicare rules, physical therapists and any other providers using the 97000 series codes should be following the "rule of eights". In our practice, our therapists spend at least 30 minutes with each patient during a routine visit. That patient is also likely to be performing a skilled therapeutic exercises program in our gym with direct contact by a physical therapist, or physical therapist assistant under the direction and supervision of the physical therapist. The direct time with the PTA, if greater than eight minutes (or 23 minutes) allows us to bill one (or two) units of therapeutic exercise in addition to the two units of manual therapy or neuromuscular re-education, totaling three, or occasionally four, units of direct contact time. If an unlicensed PT tech/aide supervises the exercise, then a charge for therapeutic exercise can not be generated.

At the proposed fee schedule, the allowable amounts will be reduced substantially and will severely cripple our practice. At those rates, the allowable amounts are barely above our break even point. With appropriate use of CPT codes, we would have a difficult time justifying a reason to participate with the Medicare program. The proposed rate cut comes at a time when other insurance companies are arbitrarily cutting their reimbursement rates. The American Physical Therapy Association is taking action to encourage them to reverse their decision as small practices such as ours will suffer severely. Perhaps focusing on fraud and abuse as a cost saving strategy would be more beneficial in the long run.

The 2002 report recently released by the Office of Inspector General identified obvious abuse of CPT codes. Many therapists and physicians are either unaware of the "rule of

eights", or choose to ignore the rule. Therefore, if they spend 20 minutes of time with the patient delivering a combination of manual therapy, neuromuscular re-education, and show the patient a few exercises before the patient performs their exercise routine with an unlicensed PT tech/aide, they think that a charge of four or five units, plus any modality charges, is appropriate. This line of thinking is rampant among physical therapists and is a major contributing factor to rising healthcare costs in the United States. I can not even begin to calculate the amount of dollars that are paid out to these unscrupulous PT's for services not delivered.

In addition to the above mentioned reasons to oppose the rate cuts, the APTA has identified several flaws in the rationale behind the proposed cuts. The "Sustainable Growth Rate" formula is projected to cause a 4.6% reduction in payments in 2007. Similar cuts are likely to total 37% by 2015. According to the APTA, the impact of these cuts would be further compounded by a budget neutrality adjuster. It is unreasonable to propose policies that add cuts on top of cuts. With such drastic and compounding cuts, the ability of practices such as ours to continue to provide care to Medicare patients will be severely compromised.

It is my understanding that payment to physicians for evaluation and management (E/M) codes will be increased by 37%. This increase will result in the 37% reduction to the rate reimbursed to physical therapist. It is unfair to punish physical therapists in this way. PT's spend a great deal of time with their patients and help to steer the plan of care that a physician may want implemented. This is a vital role that therapists serve as it improves the quality of medical care that a patient receives. It also helps to keep overall healthcare costs down by avoiding unnecessary referrals, tests, and surgeries. By effectively taking the PT's role out of the equation, the patient's medical management and healthcare in general will be jeopardized.

In summary, the impact of the proposed reduction to physical therapy reimbursement rates will severely impact the care that millions of Medicare beneficiaries receive. The proposed cuts undermine the value that physical therapists add to our healthcare system. Private practices that operate within the law in terms of their billing practices will be crippled. The fiscal repercussions will leave them unable to deliver services to Medicare patients and the patients will left to receive care from providers with lower standards of care at an overall higher cost to the Medicare program. The decision to drop these patients will be an obvious one.

Thank you for considering my comment as you look into options for preserving the quality of healthcare that millions of Americans receive. Please feel free to contact me should you have any questions regarding my comments.

Sincerely,

Joshua K. Renzi, PT, MPT
License #19295
Co-owner, Spine and Sports Rehabilitation Center

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I am writing to explain why the proposed rate cut for physical therapy services are unacceptable. As the fee schedule is structured now, BCBS's reimbursement is lower than any other payer in Maryland. Your reimbursement is ___% lower than Medicare and puts a serious strain on our ability to even cover our costs as outpatient physical therapy providers. ¶
¶
In January of 2006, the Center for Medicare/Medicaid Services (CMS) had proposed a 4% reduction in reimbursement as a part of the Deficit Reduction Act. The American Physical Therapy Association, along with the AMA and multiple other professional organizations, strongly opposed the cut and lobbied hard for reconsideration. Congress recognized that a 4% reduction was inappropriate and froze reimbursement rates at the 2005 level.¶
¶
Your proposed cut is approximately 5% of your current rates. It is unclear as to the rational that has been used to arrive at this decision. We have been told that the ... [1]

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Deleted: In our practice, our therapists spend at least 30 minutes with each ... [3]

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Deleted: Physical Therapist

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Deleted: our beak even point, and I assure you, we have made all necessary ... [6]

Deleted: In terms of costs saving to you, it seems that the logical place ... [7]

APTA Member, Private Practice Section

Page 2: [1] Deleted 8/20/2006 3:52:00 PM

I am writing to explain why the proposed rate cut for physical therapy services are unacceptable. As the fee schedule is structured now, BCBS's reimbursement is lower than any other payer in Maryland. Your reimbursement is ___% lower than Medicare and puts a serious strain on our ability to even cover our costs as outpatient physical therapy providers.

In January of 2006, the Center for Medicare/Medicaid Services (CMS) had proposed a 4% reduction in reimbursement as a part of the Deficit Reduction Act. The American Physical Therapy Association, along with the AMA and multiple other professional organizations, strongly opposed the cut and lobbied hard for reconsideration. Congress recognized that a 4% reduction was inappropriate and froze reimbursement rates at the 2005 level.

Your proposed cut is approximately 5% of your current rates. It is unclear as to the rational that has been used to arrive at this decision. We have been told that the reason for the rate cut was to keep costs down and therefore keep premiums from rising. In fact, your premiums have been rising steadily for the past several years, which is the reason why my company has dropped you from our employee benefits package and have switched to another insurance carrier.

If I may, I would like to offer another alternative for cost savings. As you know, physical therapy providers use the CPT codes in the 97000 series, as do chiropractors and other providers. According to the

Page 2: [2] Deleted 8/20/2006 3:53:00 PM

, physical therapists and any other provider using the 97000 series codes should be following the "rule of 8's". As I am sure you know, the rule states that in order to justify one 15 minute code, or 1 unit of manual therapy technique, for example, a PT must spend at least 8 minutes of direct one on one time with that patient. In order to appropriately bill a second unit of treatment, manual therapy or otherwise, the PT must spend 23 minutes of direct one on one time with the patient (15 minutes for the 1st code and at least an additional 8 minute for the second code). 3 units of charges could be billed if the PT/PTA spends 38 minutes of one on one time with the patient (30 minutes for the 1st 2 codes and 8 minutes for the 3rd). If a PT spends 25 minutes with a patient and delivers a combination of manual therapy, neuromuscular re-education and therapeutic exercises, he or she is only justified on charging 2 units (for 25 minutes) and should not be charging 3 units of direct one on one treatment.

Page 2: [3] Deleted 8/20/2006 4:18:00 PM

In our practice, our therapists spend at least 30 minutes with each patient during a routine visit. That patient is also likely to be performing skilled therapeutic exercises in our gym with direct contact by a physical therapist assistant, under the direction and

Page 2: [4] Deleted 8/20/2006 4:18:00 PM

. The direct time with the PTA (if greater than 8 minutes) allows us to bill one unit of therapeutic exercise in addition to the 2 units of manual therapy or neuromuscular re-

education, totaling 3 units of direct time. If an unlicensed PT tech/aide supervises the exercise, then a charge for therapeutic exercise can not be generated.

According to your fee schedule, the allowable amount on a charge of 3 units is only ____. At that rate,

Page 2: [5] Deleted **8/20/2006 4:22:00 PM**

we have not covered our costs. With the addition of a charge for electrical stimulation, the allowable amount has gone up to ____,

Page 2: [6] Deleted **8/20/2006 4:22:00 PM**

our beak even point, and I assure you, we have made all necessary cost cutting changes to our practice. At the proposed fee schedule rate, the allowable amounts have gone down substantially and have severely crippled our practice. With appropriate billing at this rate, we would have a hard time justifying a reason to participate with BCBS.

Page 2: [7] Deleted **8/20/2006 4:23:00 PM**

In terms of costs saving to you, it seems that the logical place to turn is to investigating fraudulent billing practices. I have spoken with many therapists who think that the "rule of 8's" applies to Medicare patients only (it does Josh!). Therefore, if they have a BCBS patient and spend 20 minutes of time with the patient delivering a combination of manual therapy, neuromuscular re-education, and show the patient a few exercises before the patient performs their exercise routine with a PT tech/aide, they think that a charge of 4 or 5 units, plus any modality charges, is appropriate. This line of thinking is rampant among physical therapists and is a major contributing factor to rising healthcare costs in the United States. I can not even begin to calculate the amount of dollars that are paid out to these PT's for services not delivered.

Conclusion???

Submitter : Dr. Larry Schick **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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

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

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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

Submitter : Ms. Sharon Fisher **Date:** 08/20/2006

Organization : Conscious Choices Counseling

Category : Health Care Provider/Association

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in Delaware and a member of the Clinical Social Work Association. I am writing to comment on the poroposed CMS cuts to reimbursement rates as proposed in CMS 1512-PN. Clinical social workers who provide more than 40% of the nation's mental health services are often the only mental health clinicians available ot our nation's ederly and disabled individuals. Several of my clients are also on very limited budgets and often cannot afford the copays involved (i.e. those for whom Medicare pays half the fee and the client is responsible for the rest and the client has no other supplemental insurance), which makes their ability to access mental health services extremely limited or virtually impossible. In several cases I have agreed to provide mental health services for these same clients on a probono basis (e.g. for clients in dire situations I have waived the copay for their portion of the copay for their mental health services because otherwise they would not be able to come at all.) Nevertheless, I am concerned about the impact these cuts will have on my ability to continue to provide services to all Medicare enrollees that come to my practice. While I see most Medicare enrollees under the CPT code of 90806, I am reimbursed at a level that is 25% lower for the rate for psychologists for the exact same code and service. Keep in mind that most psychologists are males and most licensed clinical social workers are female. It is also critical to note that commercial insurance companies have gotten legislation passed that required them to reimburse mental health professionals only at a percentage of the rates set by Medicare, which is significantly lower than medicare reimbursement rates. The outcome of this is that my income never goes up for years while expenses continue to climb. There is a continually growing shortage of Licensened Clinical Social Workers across the country at this time as LCSW workers continue to age and enrollment in Social Work training programs drops specifically because younger people are fully aware that it is extemely demanding, specialized work that is difficult to make a living wage in this field. Overhead expenses continue to rise and as a self-employed individual, my current health insurance which covers only my own health care is higher than my monthly mortgage. Lowering the reimbursement rates any further, as the 14% proposed cuts would allow, would make it impossible for me to continue staying in this line of work, let alone contine to serve the Medicare enrollees I currently treat.
I urge you to withdraw the current proposed cuts in reimbursement to LCSW mental health providers if you wish to avoid creating an even bigger health care crisis for this country than we are currently facing. I would also request that you strongly consider changing the inequitable reimbursement system that currently exists and implement equal pay for equal work, services, and codes.
Sincerely, Sharon Fisher

Submitter : Dr. Tomasz Szerszow **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

GENERAL

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

Submitter : Dr. Howard Weiss **Date:** 08/20/2006

Organization : Rockford Anesthesiologists Associated, LLC

Category : Physician

Issue Areas/Comments

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Submitter : Ms. Judith Donovan **Date:** 08/20/2006

Organization : Ms. Judith Donovan

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

IT is very important that you do NOT reduce work values by 7 % for clinical social workers. This will impact my practice and thus is a diservice to Medicare folks. I request CMS withdraw the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Medicare provicers. I also requst you select a formula that does not create a ngative impact for mental health providers. It is ultimately the clients that suffer and in this country of wealth we need to care for eachother and those less fortunate not take away services or lower the pay for the service providers. We are engaged in life and death issues at times and deserve to be valued.

Submitter : Ms. Loren Gelberg-goff **Date:** 08/20/2006

Organization : Ms. Loren Gelberg-goff

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

A 14 percent reimbursement cut will negatively affect my practice and me as a Medicare provider; I need to make a living, and we are already underpaid!
PLEASE DO NOT reduce work values for clinical social workers effective January 1, 2007;
PLEASE WITHDRAW the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and
PLEASE DO NOT approve the proposed "bottom up" formula to calculate practice expense.
Select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers

Submitter : Dr. Mike Schweitzer **Date:** 08/20/2006

Organization : Anesthesia Partners of Montana

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

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.

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.

Thank you
Mike Schweitzer, MD

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

Organization : **ID Copnsultanats, PA**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I want to support IDSA'S position on revison of E&M codes. We should be better compensated for complex medical decision making. It's time to emphasize thoughtful medicine and stem the tide of thoughtless procedural medicine. Economic incentive is the only effective route.
David Tanner

Submitter : **john boudeman** **Date: 08/20/2006**

Organization : **john boudeman**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I must disagree with the proposed changes in physicain reimbursement planned over the next 5 years. Proposed anesthesia cuts will further worsen patient care and acces to care. Currently anesthesia payments cannot adequately pay for nurses much less physicians who care for our elderly. When payments were originally valued the anesthesia calculated incorrectly and we have lived with this since. Further undervaluation of anesthesia care will put our seniors at risk as skilled anesthesia provider flee from our nations hospital to find jobs in surgical centers and offices taking care of younger and healthier pateints who can pay for safe care. Again, I must say NO to reducing anesthesia service payments. Furthermore, to cut payments to any physician is ridiculous since the government is already not paying enough for services for physicians to survive in practice.

Submitter : Ms. Cheyl Nastasio **Date:** 08/20/2006

Organization : Cheryl Nastasio, MSW, LCSW

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am a Licensed Clinical Social Worker have been a Medicare Provider for over 12 years. I am concerned that reimbursement for mental health services will be cut starting in 2007 while evaluation and management services will be increased. Please withdraw your proposal to increase the evaluation and mgt. services unless all reimbursements to all medicare providers are increased. Please do not decrease the reimbursement for clinical social workers. My regular expenses such as rent and utilities have continued to increase while the reimbursement has not kept up with these rising costs. Please do not use the "bottom up" formula to calculate practice expenses. I provide a necessary service and current research shows that there is a very strong connection between the mind and body. Depressed and anxious people use alot of services from the healthcare system. By decreasing the mental health issues the medical spending will decrease. Please do not reduce the work values for clinical social workers effective 1/1/2007. Thank you, Cheryl Nastasio, MSW, LCSW

Submitter : **Ms. Anne B. Belt** **Date: 08/20/2006**

Organization : **Eastern Connecticut Rehabilitation Centers**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

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

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

Dear Dr. McClellan:
I am troubled by the June 29th proposal to change the methodology for calculating practice expense RVUs under the Medicare physician fee schedule. This formula is projected to cut the payments by 4.6% in 2007, with further reductions up to 37% by 2015.

I have been a practicing physical therapist for 8 years, earning my Master s degree from Columbia University. I practice in an out-patient orthopedic setting. Approximately 1/4 of my patients are Medicare recepients.

Physical therapy has been proven, time and again, to be cost effective and valuable to the quality of life and independence of Medicare patients, be they elderly or disabled. The one-on-one training, guidance, manual work and education that we provide is not duplicated in any other arena of the medical field. Please do not allow for this reduction in value of our physical therapy services to Medicare recepients.

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

I appreciate your time and attention to this very important issue .

Sincerely,

Anne B. Belt, PT, MS
69 Rosemary St, #2
New London, CT 06320

Submitter : Ms. Beth Maris **Date:** 08/20/2006

Organization : NE Columbia Psychotherapy Practice, Inc.

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Licensed Clinical Social Worker in South Carollina 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.
In addition, most of my patients cannot afford to make co-pays because they cannot afford most of their medications,groceries and living expenses if they use extra monies to pay me. I basically am paid the medicare reimbursement which is far below that of my psychologisst colleagues. I can assure you that they are not willing to do the same for their patients as I do. I would appreciate your withdrawing the current proposed cuts in reimbursement to LCSW mental health providers. In addition, I hope you will consider changing the inequitable reimbursement system that currently exists, and implement equal pay for equal codes.

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

Organization : Cardiology Advocacy Alliance

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

see attachment

CMS-1512-PN-2052-Attach-1.PDF

CMS-1512-PN-2052-Attach-2.PDF

Attach #
2052

CARDIOLOGY
ADVOCACY
ALLIANCE

National leadership on issues that affect cardiovascular patients and their physicians 734.878.5449 ▪ mburrage@cardiologycaa.com

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

August 21, 2006

Dear Dr. McClellan:

On behalf our 3,700 members, the Cardiology Advocacy Alliance (CAA/Alliance) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the June 29, 2006 Proposed Notice re: Proposed Changes to the Practice Expense (PE) Methodology and the Five-Year Review of Work RVUs under the Physician Fee Schedule.

The Cardiology Advocacy Alliance represents more than 220 private practices and 3,700 cardiologists. The CAA is concerned that the changes currently proposed by CMS to the practice expense portion of the Relative Value Unit (RVU) system are based on incomplete data and a flawed methodology. The CAA requests that CMS delay implementation of the rule for one year until (1) data are corrected to accurately reflect the direct and indirect costs of providing care, and (2) the methodology is updated to better reflect the ratio of direct to indirect costs. CAA's comments on the five-year review of the Work RVUs under the Physician Fee Schedule also are included below.

Comments regarding Proposed Changes to the Practice Expense Methodology

The Alliance wants to ensure that the revisions to the practice expense component of Medicare's RBRVS are methodologically sound and are driven by accurate, representative data on physicians' practice costs. Our members are particularly concerned about the methodology, data sources and assumptions used to estimate the direct and indirect practice expense costs associated with cardiovascular CPT codes, including services performed in cardiac catheterization labs.

The rule as currently proposed is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component (TC) is a significant part of the overall procedure. **The CAA will use catheterization procedures as an example as outlined below of the impact of the proposed methodology on all procedures with significant TC costs. We also believe**

that the same solution should be applied to all procedures with significant TC costs. (The Alliance has requested via letter and e-mail correspondence to Mr. Herb Kuhn on July 31, 2006 that CMS delay the comment period for the proposed rule on practice expense changes to allow concerned parties additional time to analyze additional CPT codes to determine if the indirect and direct costs have been adequately addressed in the proposed rule. Mr. Kuhn has not yet indicated whether the request to extend the comment period will be granted.)

With regard to catheterizations: the proposed change in PE RVUs would decrease payments for CPT 93510 TC by more than 53 percent. Payment for two related codes--93555 TC and 93556 TC - also would decrease significantly. Under the Medicare Physician Fee Schedule (PFS), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

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

The stated purpose of the proposed change to a bottom-up cost approach is consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comply with the statutory requirement to match resources to payments. After reviewing the proposed methodology, including the 19-step calculation, the Alliance and other organizations have identified several flaws that result in an underestimation of the resources needed to provide the technical component of cardiac catheterizations:

Direct Costs

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

Even if the RUC estimates included the additional costs submitted by SCAI, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns.

For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients. Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

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

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

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

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

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

Indirect Costs

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

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

Summary of CAA's comments on the Proposed Rule re: Practice Expense changes

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

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterizations. Should CMS adopt its proposed rule on practice expenses as it is currently written, the unintended consequences would be significant:

1. Insufficient reimbursement would force outpatient cath labs to close. Medicare patients would be directed back to the inpatient setting for cath services. This runs counter to CMS' long-term goal of providing care in the outpatient setting whenever clinically appropriate.
2. Hospitals are not prepared to handle a large influx of catheterization cases, and the resulting wait times may very well endanger Medicare beneficiaries who need these critical cardiac services.
3. Medicare beneficiaries' out-of-pocket costs would increase, as hospital co-pays are up to 40 percent higher than those in the outpatient setting.
4. Medicare patients also would be inconvenienced by longer drive times and increased waiting periods for test results.

5. Driving Medicare patients back into the hospital setting for imaging tests also would include increased costs to the Medicare program as a whole.
6. Physician practices are small businesses, employing hundreds of thousands of people and providing valuable services to the Medicare population. The physician sector must have stable reimbursement patterns that keep pace with the increasing cost of providing care.

The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. The CAA is concerned that the problems with the catheterization codes as outlined above may extend to other CPT codes with significant TC costs as well, since the inadequate funding of catheterization codes illustrates that the data and formula used to calculate practice expense components is incomplete and inaccurate. As a result, **the Alliance requests that CMS delay implementation of the practice expense changes for one year. During this time period, CMS, RUC, SCAI, CAA and other interested parties will be able to complete a thorough assessment of the direct and indirect cost data and the methodology currently under consideration to ensure that they are accurate and complete. CAA will be collaborating with our members and other organizations to develop improved estimates of direct costs and to offer additional comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007.**

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

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

Sincerely,

Margo L. Burrage, CAA Administrator
On behalf of the Cardiology Advocacy Alliance
mburrage@cardiologycaa.com
11065 Homeshore Drive
Pinckney MI 48169
Phone: 734.878.5449

Submitter : Arondelle Schreiber **Date:** 08/20/2006

Organization : Private Practice

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

A 14% reimbursement cut would greatly negatively impact my income and prevent me from accepting new meidicare part B patients.(CMS-1512-PN) Preventing social work clinicians from serving medicare patients would have debilitationg consequences for the population of medicare clients requiring mental health services. CMS would be failing in it's mandated mission. Thus,CMS must not reduce work values for clinical social workers effective January 1, 2007. I am urging CMS to withdral the proposed increase in evaluation and management codes until they have the funds to increase reimbursemsnt for all Medicare providers. Having persons in need of mental health serves evaluated without clinicians available to provide serves is unconsiousable. I further reqest CMS not to approve the propsed 'bottom up' formula to calculate practice expenses. Rather, a formula be selected that does not create a negative impact for clinical social workers (and paychologists) who have little practice expenses as providers. Your urgent reconsideration and renewed action on these matters is needed.

Submitter : Mrs. Mary Aldred-Crouch **Date:** 08/20/2006

Organization : Lincoln Primary Care Center, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

Practice Expense

Practice Expense

RE: CMS-1512-PN

Attached please find my comments on CMS-1512-PN

CMS-1512-PN-2054-Attach-1.DOC

Attach #
2054

RE: CMS-1512-PN

I am writing with regards the proposed revisions to the Medicare Physician Fee Schedule, specifically the reduction of the RVU and the Practice Expense values. These revisions would result in reduction of reimbursements of up to 14% by the year 2010 for clinical social workers (**file code CMS-1512-PN**). I implore you to withdraw the proposed 2% reduction in Practice Expense values and 7% reduction in work values to be effective January 1, 2007. I further urge you to withdraw the 10% in reimbursement for evaluation and management codes, which are typically restricted to physicians. Please delay these increases until there is sufficient funding for all covered professional.

Clinical Social Workers, whose training is somewhat equivalent to an M.D's in terms of years of study, supervised practice and board exams required for licensure, already have very little practice expenses as providers and an additional reduction would leave most practitioners unable to survive financially and continue to practice.

The 1999 Surgeon General's report on mental health (USDHHS, 1999) clearly states that we have a mental illness epidemic in this country. The largest group of mental health practitioners are clinical social worker. By crippling clinical social workers and driving many of them out of mental health due to absurdly low reimbursement rates, the mental health crisis in the US will only worsen.

Financially, if clinical social workers are eliminated or drastically reduced in the mental health provision equations, many people, unable to find help elsewhere, will end up in their primary care physicians' offices. Physicians' offices and primary care centers will be unable to employ clinical social workers due to low reimbursement rates, preventing adequate mental health services in primary care. Reducing reimbursements to clinical social workers and increasing reimbursements to physicians will result in dramatic cost ***increases*** to the already strained-financial Medicare and Medicaid programs.

Please, I beg you, not to approve the "bottom up" formula for calculating practice expenses. Fail the 2% and 7% decreases for clinical social workers and postpone the 10% increase in evaluation and management codes until funding exists to do so without cuts to clinical social worker.

Thank you for your consideration of the above.

Regards,

Mary Aldred-Crouch, MSW, LGSW, CCAC
Primary Care Behavioral Health Provider
Lincoln Primary Care Center, Inc.
7400 Lynn Avenue
Hamlin, WV 25523

Submitter : Dan Campbell **Date:** 08/20/2006

Organization : Dan Campbell

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am concerned about the proposed changes to CMS-1512-PN. A 14 percent reimbursement cut will reduce the number of Medicare providers available to eligible patients. Many clinicians would no longer be able to afford to be a provider. I would like to request that CMS not reduce work values by seven percent for clinical social workers effective January 1, 2007. In addition, I would also like to request that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers. Finally, I would like to request that CMS not approve the proposed Top down formula to calculate practice expense. It would be much better to select a formula that does not negatively impact mental health providers.

Thank you,
Dan Campbell, LCSW

Submitter : Ms. Janae House **Date:** 08/20/2006

Organization : Va. Society of Clinical Social Workers (VSCSW)

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am a licensed clinical social worker in Va.& see a number of disabled & elderly clients(in my mental health counseling practice) who have Medicare. The 14% reduction would cause a significant hardship in my practice as my expenses continue to rise. My cost for billing has increased & rent will rise in '07. As a social worker, I have my heart with clients who have less, but unless I can meet expenses, I can't continue to serve Medicare clients. I am aware that a number of mental health professionals, including physicians,no longer to accept Medicare.

I also request that CMS not decrease work values by 7% for clinical social workers in Jan, '07. I feel the proposal for an increase in evaluation & management codes should be withdrawn until an increase can be effected for all Medicare providers.

Lastly, I believe the "Top down" formula to calculate practice expenses is unsatisfactory. I respectfully request a formula that does not negatively impact mental health providers.

Your attention to this is greatly appreciated.

Sincerely,
Janae W. House, LCSW
9844 Lori Rd, Suite 100
Chesterfield, Va. 23803
804-751-0453

Submitter : Mr. Glen Denlinger **Date:** 08/20/2006

Organization : Charis Center, Inc.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

The plan to reduce medicare part B payment for psychotherapy services to social workers and psychologists has the potential to end our professional counseling practice in Sarasota Florida for which I am executive director. Mental health cuts over the last 5 years have resulted in our inability to raise staff members salaries for the last 3 years. We are in dire need of additional payment for services to maintain our practice.

Glen Denlinger LCSW
Executive Director
Charis Center, Inc.

Submitter : **Ms. marbeth gras** **Date: 08/20/2006**

Organization : **new leaf family services**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Practice Expense.

I am a therapist in private practice. Though I have many non-medicaid clients, I continue to see medicaid clients because I value helping those who do not have access to as many therapy services.
However, I do so at a financial loss, earning sometimes half my regular fee. If medicaid reimbursement goes any lower than it is now, I will no longer be able to afford to serve these clients, and will need to stop accepting medicaid. I imagine many of my colleagues will do the same. Please stop cutting essential services to those who need it most.
Sincerely,
Marybeth Gras, LCSW
If medicare/medicaid reimbursements

Submitter : **Mary Puschel** **Date: 08/20/2006**

Organization : **Mary Puschel**

Category : **Social Worker**

Issue Areas/Comments

Other Issues

Other Issues

Social Workers are specially trained to assist the client in the environment they are in, we are quicker at getting to the issues. I am not comfortable keeping someone in therapy just to explore their childhood issues once their current issues are resolved. I believe LCSW should have the respect of the medicaid office, as they are goal driven. I resolve this clients issues in a timely manner because I know there are many more clients with issues waitting to come in to my office. However, I do need to make a living. As much as I have looked down on clinicians who have moved to only taking higher paying insurances... I am also realizing that I do need to make a living... my student loans don't cut me any breaks!! You will make your decision as far as reimbursing me for the work I am clearly doing... and from your decision I will decide if I can afford to work with the clients I enjoy the most.

Please don't cut our reimbursement, it will be unfair not only to us but to the families we see.

Mary C Puschel