Submitter : Dr. gayle frazzetta **Date:** 08/21/2006

Organization : montrose wellness center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

the proposed DXA reimbursement cuts are absurd. I am a family practice physician in solo practice in rural colorado. My ability to continue to see Medicare patients relies on my ability to supplement my income. The bone densitometer I purchased cost 75,000, plus maintence fees yearly are about 3,500. In addition I have to certify my technologist AND pay for Xray qualifications. The reports I send out are consultations and NOT computor generated. With cuts in reimbursement I will be forced to limit scans to one site and consider a summary report only. This will compromise the quality of patient care and given the decreasing rates of reimbursement over-all for primary care; may prompt my early retirement. Please review current enrollment stats for primary care- they are plummeting!!!

Submitter : **Mr. Christopher Morrow** **Date: 08/21/2006**

Organization : **Pacific Balance**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

Hello - My name is Christopher T. Morrow, and I am a physical therapist owning a clinic, Pacific Balance & Rehabilitation Clinic, in Seattle, WA. I am a Board-Certified specialist in Neurological Physical Therapy. I focus my work on managing the rehab needs of clients with walking and balance disorders. I work with people who have dizziness disorders, peripheral or central nervous system disorders, and orthopedic problems causing pain and limitations in mobility. My many functional mobility interventions included many interventions related to fall prevention.

The majority of my clients with balance, dizziness, gait, and fall disordes are elderly and are on Medicare. If CMS moves forward with payment cuts for phsyical therapists starting in 2007, my ability to adquately fund my clinic will be severely disadvantaged. I spend 60 minutes working 1-on-1 with my clients to provide quality care to meet their mobility and balance goals and needs. I love the fact that I spend more 1-on-1 healthcare time with my clients that any other provider they see. I will not be able to offer my quality PT service that optimizes movement skills and independence, and minimizes a person's fall risk and dependence upon others.

I recommend that CMS transition any changes to the work RVUs over a 4-year period to ensure that my patients and all patients continue to have access to valuable health care services, including physical therapy.

These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. My physical therapy work at Pacific Balance & Rehabilitation Clinic helps to maintain clients' independent and safe ambulation, and helps them to lead more active and healthy lives. I believe that reducing people's risk of falls and improve their ability to safely manage their mobility needs is essential in the health of our aging society. And my physical therapy interventions will end up saving Medicare money through maintaining better client health and safety.

Thank you for considering my comments. Please feel free to contact me if you have any further questions.

Sincerely,

Christopher T. Morrow, PT, NCS
Pacific Balance & Rehabilitation Clinic
cmorrow@pbrcseattle.com

Submitter : Dr. Brian Schroeder **Date:** 08/21/2006

Organization : Covenant HealthCare, Saginaw, MI

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am the director of a twelve physician group of hospitalists. We wholeheartedly support the proposed increases in the RVU for E/M services.

Today's inpatient work is more complex: we are seeing sicker and more complicated patients; they often require multiple visits to see them throuout the day, coordinating care across multiple secialties; time spent at the bedside is increasing as we explore patients' and families' wishes.

As physicians that practice entirely within the hospital, we see an ever increasing severity of illness amongst our inpatients. We excel in initiating treatment in the hospital, then finding a lesser expensive arena in which to deliver the care (e.g. home care, nursing home, etc.). Nonetheless, it is our experience patients present to the hospital with more advanced illnesses that are complicated by multiple co-morbidities.

Pleae reject any effort to LOWER the overall improvements in work RVUs for E/M services.

Submitter : Ms. janice victor **Date:** 08/21/2006

Organization : New Jersey Society for Clinical Social Work

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-2063-Attach-1.RTF

Attach FF
2063

New Jersey Society for Clinical Social Work

AFFILIATE OF THE CLINICAL SOCIAL WORK GUILD

Monday, August 21, 2006

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

Dear Decision-Maker,

On behalf of our members, The New Jersey Society for Clinical Social Work (NJSCSW) urges you not to reduce work values for clinical social workers.

Many of our members are in private practice and currently serve the mental health needs of medicare recipients. A 14% reimbursement cut would represent a severe income loss, especially since the current totally approved fee for the code is already lower than usual and customary fees.

If, indeed, these reductions represent an effort to balance the medicare budget, we would like to point out the following:
1. Mental Health treatment is reimbursed at only 50% compared with medical treatments of 80%. Therefore you are balancing the budget in the most inefficient manner.
2. The proposed increase in evaluation and management codes should be postponed until funds are available to increase reimbursement for all medicare providers
3. In addition,we recommend that CMS not approve the proposed "bottom up" formula to calculate practice expense. Please select a formula that does not create a negative impact for clinical social workers who have relatively low practice expenses as providers.

Furthermore, we believe that this decrease may create a severe shortage of clinical social workers willing to accept medicare patients, and thereby decrease access to services.

Sincerely,

Janice M. Victor, LCSW, President,
New Jersey Society for Clinical Social Work

Submitter : Dr. C Keith Stevens **Date:** 08/21/2006

Organization : Anesthesia Associates of Charleston

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sir,
As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties.

The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses.

CMS should gather new overhead expense data to replace the decade-old data currently being used.

ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.

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

Sincerely,

C. Keith Stevens, MD

Submitter : Dr. Pradipta Chaudhuri **Date:** 08/21/2006

Organization : Nebraska Heart Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1512-PN-2065-Attach-1.DOC

Attach #
2065

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

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

08/18/2006

Dear Dr. McClellan:

On behalf of Nebraska Heart Institute and our 33 individual practicing physicians, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

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

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

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

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

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

Direct Costs

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

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

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

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

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

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

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

Indirect Costs

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

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

Solutions

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

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

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

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

Sincerely,

Pradipta Chaudhuri, MD FACC

Cardiovascular Disease

Mary Lanning Hospital

Hastings, NE 68901

Submitter : Ms. Becky Allen **Date:** 08/21/2006

Organization : Clinton Memorial Hospital

Category : Hospital

Issue Areas/Comments

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

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

August 21, 2006
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Re: CMS-1512-PN
CPT Codes 76082 and 76083
Dear Sir or Madam:
We recommend that CMS withdraw its proposed reduction for the technical component of CAD until such time that providers can differentiate between utilization of CAD with analog or digital mammography. The CPT codes for CAD with mammography (76082, 76083) contain the phrase, with or without digitization of the film radiographic images .
These revisions reflect changes in medical practice, coding changes, new date on relative value components, and the addition of new procedures that affect the relative amount of physician work required to perform each service as required by statue. There have been no changes to substantiate this proposed rule for the use of CAD with analog mammography.

Sincerely,
Becky Allen, CRA, MS
Radiology Manager

Submitter : Dr. David Parrish **Date:** 08/21/2006

Organization : Consultants in Cardiology

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

see attachement

CMS-1512-PN-2067-Attach-1.DOC

Attach
2067

August 21, 2006

David l. Parrish, MD, FACC
Consultants in Cardiology
1300 W. Terrell, suite 500
Fort Worth, Texas
76104

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

Dear Dr. McClellan:

On behalf of myself and our 13 individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

We practice Cardiology in Fort Worth, Texas. We have a busy outpatient lab, evaluating roughly 15-20 patients per week with diagnostic coronary angiography and left heart catheterizations. We have been providing safe and accurate procedures to our community for the past 9 years.

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

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

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

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

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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.

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

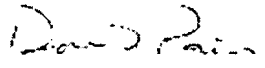
Solutions

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

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

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

Sincerely,



David L. Parrish, MD, FACC

Submitter : Mr. Benjamin Ross **Date:** 08/21/2006

Organization : South Carolina Internal Medicine

Category : Physician

Issue Areas/Comments

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

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

It has come to my attention that proposed changes to the Medicare Physician Fee Schedule (CMS-1512-PN, RIN 0938-AO12) would result in a net reduction of 80% of technical and 50% of professional reimbursement for CPT code 76075 (DXA of the axial skeleton) over the next 4 years. I believe CMS calculation fo the operating costs and utilization of this services for RVU is based on pencil beam DXA technology, not fan-beam.

Fan beam technology and the associated complex medical equipment used to scan the entire patient is MORE complex, time intensive, and costly than previous technology. The licensure requirements and expertise of those personnel performing the tests as well as the advanced analysis performed in interepretation by physicians is of a complex and time consuming nature. Furthermore, the equipment itself is vastly more expensive that pencil-beam equipment and the resulting clinical quality is apparent.

For the sake of maintaining high quality services for the population most in need of this vital service, I respectfully request that you examine the methodology used to calculate the RVU and CPT reimbursement for CPT code 76075 going forward and make certain that the correct technology is being evaluated.

Submitter : Ms. Linda Ariel **Date:** 08/21/2006

Organization : Ms. Linda Ariel

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am requesting that CMS not reduce work values for clinical social workers effective January 1, 2007; there needs to be parity among the providers of services for our clients.

Therefore, I am requesting that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers.

Submitter : Cynthia Swain **Date:** 08/21/2006

Organization : Bonnie Saks, MD

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

As practice manager, I am writing on behalf of our clinical social worker, Cynthia Swain. A decrease in her fee schedule will negatively impact our entire practice. She is one of six providers who support this office. Her schedule is full so she cannot see more patients to offset the loss of income. Please reconsider this cut.
Mary Ann Pickard, manager

Submitter : Dr. Stephen McAdams, MD, FCCP **Date:** 08/21/2006

Organization : Mid Carolina Cardiology

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

see attached

CMS-1512-PN-2071-Attach-1.PDF

Attach #
2071

Mark McClellan, MD, 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:

Mid Carolina Cardiology 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.

Mid Carolina Cardiology represents 31 physicians and 200 employees who serve more than 150,000 patients in the greater Piedmont area of Charlotte and surrounding cities of North Carolina. We, along with more than 220 private practices and 3,700 cardiologists as represented by the Cardiology Advocacy Alliance (CAA), are 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. [name of practice] 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. Our 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

Mid Carolina Cardiology 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 physicians 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. Mid Carolina Cardiology (MCC) **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.**

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

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

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

Direct Costs

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

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

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

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

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

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

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

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

Indirect Costs

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

utilization estimate for 93510 TC, and Cardiology. The IDTF survey includes a wide range of facilities, but does not reflect the cost profile of cardiac catheterization facilities that may have a cost profile similar to Cardiology in terms of the higher indirect costs that are associated with performing these services.

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

Summary of Mid Carolina Cardiology comments on the Proposed Rule re: Practice Expense changes

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

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

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

The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. We are concerned that the problems with the catheterization codes as outlined above may extend to other CPT codes with significant TC costs as well, since the inadequate funding of catheterization codes illustrates that the data and formula used to calculate practice expense components is incomplete and inaccurate. As a result, **Mid Carolina Cardiology 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

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

Sincerely,

Stephen A. McAdams, MD, FCCP
smcadams@mccardiology.com
On behalf of Mid Carolina Cardiology, PA
1718 E. 4th Street, Suite 901
Charlotte, NC 28204
704-347-2058

Submitter : Dr. Mark Mathis **Date:** 08/21/2006

Organization : Greenville Anesthesiology, P.A.

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

Please don't enact further cuts to the specialty of Anesthesiology for these reasons: 1) It has already suffered more CMS cuts than most other specialties 2) There is already a shortage of Anesthesiologists and this will create even less incentive for medical students to choose it as a career path 3) If M.D.s slowly disappear from the specialty then all the gains made in safety and quality of the anesthetic drugs and techniques will be lost. Remember, it is mostly the advances in anesthesia that have improved, in fact made possible, many of the high risk surgeries performed today. Thank you for your consideration.

Sincerely,

Mark Mathis, M.D.

Submitter : Dr. D.Mark Robirds **Date:** 08/21/2006

Organization : Greenwood Internal Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Subject: CMS-1512- PM

To Whom It May Concern:

We are physicians in an internal medicine practice who believe strongly in preventive medicine. We have had a bone dexa machine in our office for at least the past five or six years and believed by using the machine on a regular basis at intervals and addressing abnormalities that we have reduced the incidence of vertebral compression fractures and hip fractures in our elderly population.

Now we hear that CMS is considering a reduction in reimbursement, a substantial reduction in reimbursement, for this service. We have heard that we are looking at as much as an 80% reduction in the technical portion for reimbursement and a 50% reduction in professional component.

Preventive medicine takes time, attention, and money. With such drastic reduction in reimbursement as is threatened by the proposed new fee schedule, we feel that we will no longer be able to deliver the service to our patients. The profit margin for doing the procedure in office is already marginal, but adequate to justify extending the service. We do not anticipate being able to provide the service for the reimbursement rates being proposed

We ask that you reconsider. Being heavy handed with the fee reduction will do nothing but separate hundreds of patients from state-of-the-art management of their osteoporosis.

Sincerely,

D. Mark Robirds, M.D.

G. P. Cone, Jr., M.D.

Carlos M. Manalich, M.D.

Kimberly E. Russell, M.D.

Rebecca Martin, M.D.

Allan P. Turner, M.D.

Submitter : Jason **Date:** 08/21/2006

Organization : Jason

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment on the June 29th proposed notice regarding possible decreases in medicare reimbursement for physical therapy services. It has recently been brought to my attention that medicare is considering measures which will decrease medicare's payments for physical therapy treatments for their patients. As a practicing physical therapist, I am familiar with the hardships in our seniors that limitations in physical therapy/rehabilitation services can produce. These hardships include extensive pain that may severely limit function, stiff joints, loss of functional mobility and independence, decreased quality of life, and more of a dependency on others (family and formal care), leading to increased burdens and costs in other areas. Without adequate physical therapy, patients will likely need more expensive care (long term care, hospitals, nursing homes) earlier than otherwise. Physical therapy, rehabilitation and regular exercise helps keep the patient's quality of life and independence at higher levels for longer. I, as a practicing physical therapist, would like to strongly urge and request that CMS not implement medicare payment cuts for physical therapists and other healthcare professionals. Another issue is anodyne/infrared treatments for neuropathy. I have seen improvements in several patients with neuropathy in sensation, pain, and general function as a result of anodyne/infrared treatments. Sometimes these patients have had symptoms for years, and have tried other treatments with little to no effect. I would also like to urge CMS that reimbursement for infrared/anodyne treatments not be decreased or eliminated. Thank you for considering my comments.

Submitter : **Dr. Richard D. Gordon** **Date: 08/21/2006**

Organization : **Rheumatology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2075-Attach-1.DOC

Attach #
2075

RHEUMATOLOGY ASSOCIATES

Consultants in Arthritis, Musculoskeletal and Connective Tissue Disorders

Richard D. Gordon, M.D., P.A
Janet F. Krommes, M.D.
Leigh G. Segal, M.D.
Robert H. Gordon, M.D.

September 18, 2006

Centers for Medicare & Medicaid Services

Re: CMS-1512-PN

Dear Sir or Madam:

I am writing to express my tremendous concern about CMS-1512-PN.

I am a rheumatologist and have been in practice for over 25 years. I have seen the tremendous strides made in PREVENTING disease such as broken hips and backs simply by screening woman with DXAs. Unfortunately, the machines used (Fan beam) cost over $50,000 to start. I do not know anyone who uses the cheaper and less accurate pencil bean technology.

I also employ a registered radiology technician at a cost of over $40 per hour. We can do one study every 45 minutes. I convey the results to referring doctors and the patients. I also must rent the space for this large unit, have a physicist come by yearly to check it out, maintain the unit, etc. How could we afford to offer this service if the fees are cut so drastically?

Please help us care for our patients. This is the LEAST expensive high tech thing we offer our patients with the most return as far as preventing fracture and keeping people alive. If the cost was cut any lower than current reimbursement, I would just close up.

Respectfully submitted,
Richard D Gordon MD

2275 Whitehorse-Mercerville Road
Suite 8
Mercerville, NJ 08619
(609) 587-9898
Fax (609) 584-1774

Oxford Square
380 Middletown Blvd., Suite 704
Langhorne, PA 19047
(215) 757-5665
Fax (215) 757-3128

Submitter : Ms. Leonora Augustin **Date:** 08/21/2006

Organization : Ms. Leonora Augustin

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a Social Work graduate student going into a field because I love it and realize that I will never have the type of income that some graduate degree professions obtain. That being said, it is disheartening that CMS is proposing to reduce clinical social workers reimbursement by 7 percent in work values and a 2 percent reduction in Practice Expens. I am asking that you please request CMS to select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers. This reminds me of nurses that do such a significant amount of work, but are virtually ignored professionally. This is why many hospitals have had to close down entire units due to the nursing shortages. I hope that someone will realize that our profession advocates for the most vulnerable and can not afford to lose it dedicated professionals.

Submitter : **Mr. Vincent Donlon** **Date: 08/21/2006**

Organization : **Cardiovascular Associates**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Practice Expense

Practice Expense

see attachment

CMS-1512-PN-2077-Attach-1.PDF

Attachment
2077

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:

Cardiovascular Associates, Ltd. 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.

Cardiovascular Associates, Ltd. represents 20 of physicians and 100 employees who serve more than 400,000 patients in the greater Hampton Roads area. We, along with more than 220 private practices and 3,700 cardiologists as represented by the Cardiology Advocacy Alliance (CAA), are 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. Cardiovascular Associates, Ltd. 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. Our 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

Cardiovascular Associates, Ltd. 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 physicians 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. Cardiovascular Associates, Ltd. **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.**

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
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93526 TC	Rt & Lt Heart Catheters

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

Direct Costs

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

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

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

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

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

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

Direct Cost Category	*Included In RUC- Determined Estimate*	*Excluded From RUC-Determined Estimate*
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
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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 CARDIOVASCULAR ASSOCIATES, Ltd. comments on the Proposed Rule re: Practice Expense changes

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

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

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

The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. We are concerned that the problems with the catheterization codes as outlined above may extend to other CPT codes with significant TC costs as well, since the inadequate funding of catheterization codes illustrates that the data and formula used to calculate practice expense components is incomplete and inaccurate. As a result, **Cardiovascular Associates, Ltd. 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

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

Sincerely,

Vincent W. Donlon
vdonlon@cval.org
On behalf of Cardiovascular Associates
5700 Cleveland St. Suite 228
Virginia Beach, VA 23462

Submitter : Ms. Ruth Halben **Date:** 08/21/2006

Organization : University of Michigan Hospital & Soka Services

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I strongly object to the proposed FEE Reduction for Social Workers under Medicare. Many of the patients I see in the home setting would increase Medicare costs by inappropriately accessing the healthcare system if it were not for the provision of education and support that they receive from social workers like me. In the whole scheme of the health care system, social work is a very small piece. More focus should be put on prescription medications and educating patients about the Part D Program.

Submitter : Dr. Ladon Homer **Date:** 08/21/2006

Organization : Texas Medical Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2079-Attach-1.DOC

the budget neutrality adjustment to the RVUs was previously a major factor in creating physician distrust of the RBRVs methodology, and we urge you not to revive that unwise methodology. Keeping the budget neutrality adjustments in the conversion factor over the past 8 years has allowed the RVUs to gain credibility as a method for setting fees, calculating costs, negotiating contracts and benchmarking practices. When budgetary considerations are used to set RVU values, physicians distrust their validity as a method of valuing resource inputs, especially regarding practice expense values.

Additionally, many private sector payers, including Blue Cross Blue Shield plans, and managed care organizations, are using variations of the Medicare RBRVS to set physician reimbursement. While the proposed rule is written solely from the perspective of the Medicare program, it is unrealistic not to also consider the impact that the budge-neutrality adjustment to the RVUs will have on the level of physician payments overall.

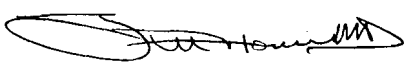
We are aware that the budget neutrality factor problem is related to the current problems with the SGR update methodology. We ask you to continue to urge Congress to implement a permanent revision to this methodology, by eliminating the erroneous SGR methodology. Whether Congress acts on this matter or not, we urge you to make the budget neutrality adjustments by incorporating them into the conversion factor, not by adjusting the RVUs.

Practice Expense

We agree that the practice expense RVU methodology needs revision, particularly to the extent that it is dependent on outdated AMA SMS survey data. Relying on old data is particularly problematic because practice expenses have been increasing faster than medical inflation over the past two decades. The reliance on old data, even when updated by inflation factors, thus will understate actual costs. The CMS methodology which uses a 5-year average instead of the most recent data exacerbates that understatement. We would support the collection of current data from all specialties using a consistent data collection instrument and methodology. The use of data that is not consistent across all specialties will lead to erroneous results. Our experience with physician surveys leads us to believe that physician compliance and reporting will be greatly enhanced if the actual data collection is done by a trusted source such as the AMA. We would urge CMS to work with the AMA to collect new data and to use the most current data available as soon as possible.

Thank you for the opportunity to comment.

Sincerely,



Ladon W. Homer, MD, President
Texas Medical Association

Attach # 2079

August 21, 2006

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

Dear Sirs:

On behalf of the nearly 42,000 physician and medical student members of the Texas Medical Association, we thank you for the opportunity to comment on "Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology" published in the Federal Register on Thursday, June 29, 2006. We appreciate your continuing efforts to revise relative values, and improve the RVU calculation methodology, but we have some concerns about the current proposal.

Work RVU Revisions

Although we have not reviewed the survey data or other supporting evidence for the RVU changes, we respect and appreciate the hard work and analysis of the AMA/Specialty Society RVS Update Committee (RUC). We thank you for accepting the large majority of their recommendations and urge you to continue to work with them and the relevant specialty societies to resolve the remaining data and evidence issues so that all the RUC recommendations can be implemented.

With regard to the changes in work RVUs for evaluation and management services, we appreciate your acknowledgement that those services were previously undervalued as a result of incorrect assumptions. Cognitive work is an important part of the work performed in patient visits, including those visits that are part of global surgical services. We commend you for recognizing that the RVUs for the previously undervalued services needed to be increased, and for acting to increase RVUs for E&M services, and to immediately incorporate the appropriate increases for all global surgical services.

Budget Neutrality

We are very disappointed with the current proposal to adjust the RVUs for budget neutrality, as CMS had abandoned that flawed methodology many years ago in favor of an update methodology that applied all budget neutrality adjustments to the conversion factor. Applying

Submitter : **Dr. Mark Masters** **Date: 08/21/2006**

Organization : **Jacksonville Heart Center**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

See Attachment

CMS-1512-PN-2080-Attach-1.DOC

A Hac -7
2080

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:

Jacksonville Heart Center 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.

Jacksonville Heart Center represents 17 physicians and 122 employees who serve more than 20,000 patients in the greater Northeast Florida and South Georgia area. We, along with more than 220 private practices and 3,700 cardiologists as represented by the Cardiology Advocacy Alliance (CAA), are 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. Jacksonville Heart Center 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. Our 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

Jacksonville Heart Center 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 physicians 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. Jacksonville Heart Center 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.

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

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

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

Direct Costs

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

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

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

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

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

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

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

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

Indirect Costs

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

utilization estimate for 93510 TC, and Cardiology. The IDTF survey includes a wide range of facilities, but does not reflect the cost profile of cardiac catheterization facilities that may have a cost profile similar to Cardiology in terms of the higher indirect costs that are associated with performing these services.

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

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

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

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

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

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

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

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

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

Sincerely,

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

Submitter : Ms. Marcia Wyrtzen **Date:** 08/21/2006

Organization : Ms. Marcia Wyrtzen

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

As a licensed clinical social worker practicing in New Jersey and as an approved medicare provider, I am strongly requesting that you not reduce work values for clinical social workers effective January 1, 2007. I believe that a much more effective alternative would be to withdraw the proposed increase in evaluation and management codes until you have the funds to increase reimbursement for all Medicare providers. My practice would be very negatively impacted by a 14% reimbursement cut, and I would be forced to stop taking people with Medicare coverage into my practice. This would seriously curtail their opportunity to receive vital mental health services, and, in some cases, could seriously endanger their emotional well-being.
Thank you for your attention to this matter.
Marcia Wyrtzen, LCSW

Submitter : **Dr. Vaughn Barnick** **Date: 08/21/2006**

Organization : **Columbia Medical Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

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

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

I am writing in reference to File Code CMS-1512-PN. My practice has been providing full Dexa scans now for approximately seven years. This is a service that has been valued greatly by our patients. We service approximately 13,000-15,000 patients with a 65% Medicare case load. More than 50% of these Medicare patients are women. I have reviewed the CMS consideration suggesting a reduction of 80% in the technical portion of reimbursement for Dexa scanning and a 50% reduction in the professional component for that same testing. This effectively would reduce reimbursement for a single study from its current level of $140.00 to $38.00. It is also my understanding that the methodology employed by CMS supporting the proposed reductions is based on pencil-beam technology as opposed to fan beam technology. This results in a serious underestimation of the actual cost to providing state of the art osteoporosis screening.
Below I would like to outline to you my practice costs for providing state of the art Dexa scanning to our patients. They are itemized as below:

Monthly Equipment Cost	$1122.00
Monthly Maintenance Cost	298.12
Technician Cost	1700.00
Space Allotment	340.00
Cert/Misc	25.00
Estimated Total Monthly	$3485.12

Our practice performs approximately 15 Dexa scans per week for a reimbursement of $1875.00 per week on a yearly basis. This results in $97,500.00 in revenue of which $41,821.41 is applied to expenses. If CMS were to reduce the Dexa reimbursement to $38.00 per study this would result in an annualized revenue of $26,640.00 against a current cost of $41,821.41 leaving a net loss of $25,357.59.

I think these numbers speak for themselves. To propose such a reduction in reimbursement will severely limit access to Dexa scanning for Medicare and non-Medicare patients. I respectfully request that you reconsider your methodologies. I would also request that you reconsider such actions especially in light of Congress's proposal to change the practice expense methodology by which healthcare providers are reimbursed.

Sincerely,

Vaughn R. Barnick, M.D.

Submitter : Ms. **Date:** 08/21/2006

Organization : Ms.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Do not cut payments to Social Workers. If Social Workers stop taking Medicare clients, Medicare clients will have great difficulty receiving services they need. Social Workers expenses, like everyone elses, are going up not down. Social Workers cannot afford to take clients if they lose money on the services they provide for these clients.

Submitter : Mrs. ODALYS VALENCIA **Date:** 08/21/2006

Organization : Mrs. ODALYS VALENCIA

Category : Social Worker

Issue Areas/Comments

Other Issues

Other Issues

The medicare cuts to SOCIAL WORKERS WILL PLACE THE ATTENTION TO GERIATRIC PATIENTS IN TERMS OF MENTAL HEALTH IN A VERY DIFICULT SITUATION. DUE THE FACT THAT THE ALREADY LOW FEES IF ARE AFFECTED AGAIN WILL AFFECT US(SOCIAL WORKERS AS A MEDICARE PROVIDER) . THE CUTS WILL AFFECT OUR ABILITY OF KEEPING A PRACTICE. AS A RESULT GERIATRIC PATIENT WILL SEE THEIR POSIBILITIES OF RECIVING PSYCHOTHERAPY SERIOUS AFFECTED.
HOPING THIS WILL BE STOP.
THANKS
ODALYS VALENCIA.LCSW

Submitter : Dr. Leslie Stuck **Date:** 08/21/2006

Organization : Columbia Medical Associates, P.A.

Category : Physician

Issue Areas/Comments

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

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

I am writing in reference to File Code CMS-1512-PN. My practice has been providing full Dexa scans now for approximately seven years. This is a service that has been valued greatly by our patients. We service approximately 13,000-15,000 patients with a 65% Medicare case load. More than 50% of these Medicare patients are women. I have reviewed the CMS consideration suggesting a reduction of 80% in the technical portion of reimbursement for Dexa scanning and a 50% reduction in the professional component for that same testing. This effectively would reduce reimbursement for a single study from its current level of $140.00 to $38.00. It is also my understanding that the methodology employed by CMS supporting the proposed reductions is based on pencil-beam technology as opposed to fan beam technology. This results in a serious underestimation of the actual cost to providing state of the art osteoporosis screening.
Below I would like to outline to you my practice costs for providing state of the art Dexa scanning to our patients. They are itemized as below:

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Monthly Maintenance Cost	298.12,
Technician Cost	1700.00,
Space Allotment	340.00,
Cert/Misc	25.00,

Estimated Total Monthly $3485.12.

Our practice performs approximately 15 Dexa scans per week for a reimbursement of $1875.00 per week on a yearly basis. This results in $97,500.00 in revenue of which $41,821.41 is applied to expenses. If CMS were to reduce the Dexa reimbursement to $38.00 per study this would result in an annualized revenue of $26,640.00 against a current cost of $41,821.41 leaving a net loss of $25,357.59.

I think these numbers speak for themselves. To propose such a reduction in reimbursement will severely limit access to Dexa scanning for Medicare and non-Medicare patients. I respectfully request that you reconsider your methodologies. I would also request that you reconsider such actions especially in light of Congress's proposal to change the practice expense methodology by which healthcare providers are reimbursed.

Sincerely,

Lesie M. Stuck, M.D.

Submitter : Dr. Frederic Smith **Date:** 08/21/2006

Organization : Columbia Medical Associates, P.A.

Category : Physician

Issue Areas/Comments

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

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

I am writing in reference to File Code CMS-1512-PN. My practice has been providing full Dexa scans now for approximately seven years. This is a service that has been valued greatly by our patients. We service approximately 13,000-15,000 patients with a 65% Medicare case load. More than 50% of these Medicare patients are women. I have reviewed the CMS consideration suggesting a reduction of 80% in the technical portion of reimbursement for Dexa scanning and a 50% reduction in the professional component for that same testing. This effectively would reduce reimbursement for a single study from its current level of $140.00 to $38.00. It is also my understanding that the methodology employed by CMS supporting the proposed reductions is based on pencil-beam technology as opposed to fan beam technology. This results in a serious underestimation of the actual cost to providing state of the art osteoporosis screening.
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Monthly Maintenance Cost	298.12,
Technician Cost	1700.00,
Space Allotment	340.00,
Cert/Misc	25.00,

Estimated Total Monthly $3485.12.

Our practice performs approximately 15 Dexa scans per week for a reimbursement of $1875.00 per week on a yearly basis. This results in $97,500.00 in revenue of which $41,821.41 is applied to expenses. If CMS were to reduce the Dexa reimbursement to $38.00 per study this would result in an annualized revenue of $26,640.00 against a current cost of $41,821.41 leaving a net loss of $25,357.59.

I think these numbers speak for themselves. To propose such a reduction in reimbursement will severely limit access to Dexa scanning for Medicare and non-Medicare patients. I respectfully request that you reconsider your methodologies. I would also request that you reconsider such actions especially in light of Congress's proposal to change the practice expense methodology by which healthcare providers are reimbursed.

Sincerely,

Frederic A. Smith, M.D.

Submitter : **Dr. Rachel Vidal** **Date: 08/21/2006**

Organization : **Columbia Medical Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in reference to File Code CMS-1512-PN. My practice has been providing full Dexa scans now for approximately seven years. This is a service that has been valued greatly by our patients. We service approximately 13,000-15,000 patients with a 65% Medicare case load. More than 50% of these Medicare patients are women. I have reviewed the CMS consideration suggesting a reduction of 80% in the technical portion of reimbursement for Dexa scanning and a 50% reduction in the professional component for that same testing. This effectively would reduce reimbursement for a single study from its current level of $140.00 to $38.00. It is also my understanding that the methodology employed by CMS supporting the proposed reductions is based on pencil-beam technology as opposed to fan beam technology. This results in a serious underestimation of the actual cost to providing state of the art osteoporosis screening.
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Our practice performs approximately 15 Dexa scans per week for a reimbursement of $1875.00 per week on a yearly basis. This results in $97,500.00 in revenue of which $41,821.41 is applied to expenses. If CMS were to reduce the Dexa reimbursement to $38.00 per study this would result in an annualized revenue of $26,640.00 against a current cost of $41,821.41 leaving a net loss of $25,357.59.

I think these numbers speak for themselves. To propose such a reduction in reimbursement will severely limit access to Dexa scanning for Medicare and non-Medicare patients. I respectfully request that you reconsider your methodologies. I would also request that you reconsider such actions especially in light of Congress's proposal to change the practice expense methodology by which healthcare providers are reimbursed.

Sincerely,

Rachel W. Vidal, M.D.

Submitter : **Date: 08/21/2006**

Organization :

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

Dear Dr. McClellan,

I am a Physical Therapist, who has been practicing in the Baltimore area for 16 years. I currently work in an outpatient facility in the 21224 zip code which is part of a certified rehabilitation agency. I primarily see orthopaedic and women s health patients. This population includes a high number of Medicare patients for such diagnoses as arthritis, joint replacements, bursitis, spinal stenosis, degenerative disc disease, osteoporosis and incontinence.

I would like to take this opportunity to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule. I would like to urge CMS to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. I recommend that CMS transition the changes to the work relative value units (RVUs) over a four year period to ensure that patients continue to have access to valuable health care services.

These proposed cuts undermine the goal of having a Medicare payment system that preserves patient access and achieves greater quality of care. If payment for these services is cut so severely, access to care for millions of the elderly and disabled will be jeopardized. Under current law, the Sustainable Growth Rate (SGR) formula is projected to trigger a 4.6% cut in payments in 2007 . This is forecasted to continue which would result in a total 37% cut by 2015. This would be further compounded by a budget neutrality adjuster proposed in the 5-year review rule that would impose additional cuts on top of the SGR. It is unreasonable to propose policies that pile cuts on top of cuts.

CMS emphasizes the importance of increasing payment for E/M services to allow physicians to manage illness more effectively and therefore result in better outcomes. Increasing payment for E/M services is important, but the value of services provided by all Medicare providers should be acknowledged under this payment policy. Physical therapists spend a considerable amount of time in face-to-face consultation and treatment with patients, yet our services are being reduced in value. Physical therapists cannot bill for E/M codes and will derive no benefit from increased payment. Therefore, 2007 will be a devastating year for physical therapists and other non-physicians who are not allowed to bill for these E/M services.

Thank you for your consideration of this matter. Sincerely,
Gretchen P.T.

Submitter : Dr. Jerry Robinson **Date:** 08/21/2006

Organization : Columbia Medical Associates, P.A.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing in reference to File Code CMS-1512-PN. My practice has been providing full Dexa scans now for approximately seven years. This is a service that has been valued greatly by our patients. We service approximately 13,000-15,000 patients with a 65% Medicare case load. More than 50% of these Medicare patients are women. I have reviewed the CMS consideration suggesting a reduction of 80% in the technical portion of reimbursement for Dexa scanning and a 50% reduction in the professional component for that same testing. This effectively would reduce reimbursement for a single study from its current level of $140.00 to $38.00. It is also my understanding that the methodology employed by CMS supporting the proposed reductions is based on pencil-beam technology as opposed to fan beam technology. This results in a serious underestimation of the actual cost to providing state of the art osteoporosis screening.
Below I would like to outline to you my practice costs for providing state of the art Dexa scanning to our patients. They are itemized as below:

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Space Allotment	340.00,
Cert/Misc	25.00,

Estimated Total Monthly $3485.12.

Our practice performs approximately 15 Dexa scans per week for a reimbursement of $1875.00 per week on a yearly basis. This results in $97,500.00 in revenue of which $41,821.41 is applied to expenses. If CMS were to reduce the Dexa reimbursement to $38.00 per study this would result in an annualized revenue of $26,640.00 against a current cost of $41,821.41 leaving a net loss of $25,357.59.

I think these numbers speak for themselves. To propose such a reduction in reimbursement will severely limit access to Dexa scanning for Medicare and non-Medicare patients. I respectfully request that you reconsider your methodologies. I would also request that you reconsider such actions especially in light of Congress's proposal to change the practice expense methodology by which healthcare providers are reimbursed.

Sincerely,

Jerry W. Robinson, M.D.

Submitter : Mr. Paul Engel **Date:** 08/21/2006

Organization : FRMH

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern:
I am writing about the proposal to cut payments to professionals such as myself, a licensed clinical social worker and to increase work (codes). At the present time, the payment is already lower than the average fee for service and this does not include the difficulties and time waiting to get paid.
In fact, with the increase in costs and perhaps work to us there should be an increase not a decrease in reimbursement. I do hope that you will reconsider and at least not devalue our work by decreasing payments for vital services in helping those with serious issues facing them.

Yours truly,
Paul Engel LCSW

Submitter : **Dr. Joseph Gard** **Date: 08/21/2006**

Organization : **Nebraska Heart Institute**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

See attachment

CMS-1512-PN-2091-Attach-1.DOC

2091

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

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

08/18/2006

Dear Dr. McClellan:

On behalf of Nebraska Heart Institute and our 33 individual practicing physicians, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practices.

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

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

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

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

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

Direct Costs

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

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

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

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

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

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

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

Indirect Costs

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

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

Solutions

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

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

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

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

Sincerely,

Submitter : Dr. Priya Venugopal **Date:** 08/21/2006

Organization : Breast Diagnostics of North Texas

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2093-Attach-1.DOC

#2093

A Comprehensive Breast Care Center

Breast Diagnostics of North Texas

CMMS
Dept. Of Health and Human Services
Attention CMS-1512-PM
PO Box 8014
Baltimore, MD 21244

Re: CMS-1512-PN

CPT Codes 76082 and 76083

We recommend that CMS withdraw its proposed reduction for the technical component of CAD until such time that providers can differentiate between utilization of CAD with analog or digital mammography.

We firmly believe that there are no changes in medical practice to substantiate this rule for use of CAD with analog mammography.

Sd: Priya Venugopal, MD
1545 E. Southlake Blvd. Suite 200
Southlake TX 76092
817-749-2000

Submitter : Dr. William Sisco **Date:** 08/21/2006

Organization : Lubbock Sports Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2094-Attach-1.PDF

CMS-1512-PN-2094-Attach-2.PDF

ATTACHMENT 1 TO #2097

August 18,2006

CMS
Dept of Health & Human Services

Attn: CMS-1512-PN

Gentlemen:

We are commenting on the proposed changes to the reimbursement for the dual energy x-ray absorptiometry (DXA). This could severely limits are abilities to perform bone scan analysis for women with osteoporosis, since the proposed reimbursement amount is below the costs of providing this services.

The initial investment for this fan-beam machine is in excess of $150,000, plus the incremental overhead costs associated with staffing, materials, utilities, maintenance, and other costs that incur on an on-going basis. Just to recover our initial investment would require over 4,000 tests, not including the associated overhead.

Please consider this information in your decision to reduce the reimbursement for this much needed preventative service.

Please let us know if you require any additional information.

Lubbock Sports Medicine Associates
William T Sisco, MD
Stephen Cord, MD
Kevin Crawford, MD
Robert King, MD
Dana Soucy, MD

Phone: 806-792-4329
Email: admin@lubbocksportsmed.com

ATTACHMENT 2 TO #2094

August 18,2006

CMS
Dept of Health & Human Services

Attn: CMS-1512-PN

Gentlemen:

We are commenting on the proposed changes to the reimbursement for the dual energy x-ray absorptiometry (DXA). This could severely limits are abilities to perform bone scan analysis for women with osteoporosis, since the proposed reimbursement amount is below the costs of providing this services.

The initial investment for this fan-beam machine is in excess of $150,000, plus the incremental overhead costs associated with staffing, materials, utilities, maintenance, and other costs that incur on an on-going basis. Just to recover our initial investment would require over 4,000 tests, not including the associated overhead.

Please consider this information in your decision to reduce the reimbursement for this much needed preventative service.

Please let us know if you require any additional information.

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