CMS-1512-PN-2274

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

Organization : Alliance of Specialty Medicine

Category : Physician

Issue Areas/Comments

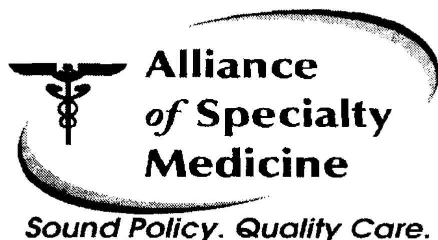
GENERAL

GENERAL

See attachment.

CMS-1512-PN-2274-Attach-1.DOC

#2274



200,000 Physicians Strong

Gordon Wheeler, Chair
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August 21, 2006

Mark McClellan, M.D., Ph.D.
Administrator
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 – Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan:

The Alliance of Specialty Medicine, a coalition of 11 medical societies representing more than 200,000 specialty physicians in the United States, appreciates the opportunity to comment regarding the budget neutrality provisions discussed in the Centers for Medicare & Medicaid Service's (CMS) notice referenced above.

Budget neutrality to account for five-year review increases in work RVUs
According to the notice, CMS expects that budget neutrality-adjustments will be required as a result of changes in RVUs resulting from the five-year review as well as other fee schedule payment policy revisions that will be announced later this year. CMS considered two options for making the statutorily required budget-neutrality adjustments to account for the five-year review of physician work:

1. reducing all work RVUs by an estimated 10 percent, or

2. reducing the physician fee schedule conversion factor by an estimated five percent

CMS notes that the application of the budget neutrality adjustment to the conversion factor would negatively impact all PFS services, whereas the application of the budget neutrality adjustment to the work RVUs would impact only those services that have physician work RVUs. Because the need for a budget neutrality adjustment is due largely to changes as a result of the five-year review, CMS is proposing a budget neutrality adjustor that would reduce all work RVUs by an estimated 10 percent to meet the budget neutrality provisions of the Medicare law.

The Alliance strongly disagrees with applying a budget neutrality adjustment to the work RVUs. To preserve the integrity and relativity of the work RVUs, the Alliance urges CMS to apply the budget

neutrality adjustment to the 2007 conversion factor rather than the work RVUs. Applying a budget neutrality adjustor to the work RVUs counteracts the purpose of updating the evaluation and management and other codes in the first place and thwarts the progress made by specialty societies, the RUC and CMS, all of which dedicated a tremendous amount of time and effort to develop accurate changes to the E&M and other work RVUs.

In addition, the vast majority of private payers use the Medicare fee schedule in their contracts with physicians, and physicians would be unfairly negatively affected if private payers used budget-neutrality adjusted work RVUs. It is naïve to believe that it would be possible to maintain two separate lists of work RVUs, one adjusted for budget neutrality and one not adjusted for budget neutrality, without generating unnecessary confusion and administrative hassles.

We also urge CMS to consider the history of how it has applied budget neutrality adjustments and the problems that arose in the past from applying it directly to the work RVUs. Subsequent to adoption of the fee schedule in 1992, CMS achieved budget neutrality by uniformly reducing all work RVUs each year. These adjustments to the work relative values caused confusion among private payers and physician practices. Also, constantly changing work RVUs hindered the process of establishing work RVUs for new and revised services. Therefore, the AMA RUC argued that any necessary budget neutrality adjustments should be made to the conversion factor, rather than the work RVUs. In 1996, CMS reversed its policy and applied the budget neutrality adjustment to the conversion factors.

In 1997, following the first Five-Year Review of the RBRVS, CMS reversed its policy once again and went back to applying budget neutrality directly to the work RVUs in the form of a separate work adjuster. However, due to problems with this approach, CMS began in 1998 to apply budget neutrality adjustments to the conversion factor and has continued to do so to date. According to CMS, "We did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUs to determine a payment amount that matched the amount actually paid by Medicare." (68 Fed. Reg. at 63246).

We are not sure why CMS is proposing to reverse back to a policy of applying budget neutrality adjustment to the work RVUs, especially when CMS itself has admitted that it causes problems and confusion. Therefore, we urge CMS to reconsider this proposal.

Use of budget-neutrality adjusted work RVUs in calculating service level allocators for indirect practice expense RVUs

In the practice expense methodology changes outlined in the notice, CMS notes that the work RVUs used in the calculation of service level allocators for the indirect PEs include the separate work budget neutrality adjustment from the 5-year review of the work RVUs. The Alliance disagrees with using the adjusted work RVUs in this PE calculation, as this arbitrarily and unfairly penalizes physicians by resulting in lower PE RVUs for procedures with work RVUs. We urge CMS to use the full newly-proposed work RVUs in calculating the indirect PE service-level allocators. In general, for any calculations used to allocate indirect costs, we urge CMS to use non-budget neutral values in those calculations.

Application of budget neutrality adjustments in practice expense methodology

In the newly-proposed PE methodology discussed in the proposal, CMS applies a budget neutrality adjustment three times – to the direct inputs, to the indirect allocators and also as a final step. It is unclear why CMS does not apply budget neutrality just once as a final step in the methodology, and we

seek clarification on the impacts of applying three separate budget neutrality adjustments in the new methodology.

Thank you for considering our comments. If you have any questions or need additional information, please contact Robin Hudson, AUA Manager of Regulatory Affairs at 410-689-3762 or rhudson@auanet.org Emily Graham, ASCRS Manager of Regulatory Affairs at 703-383-5725 or egraham@ASCRS.org.

Sincerely,

American Academy of Dermatology Association
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
North American Spine Society
American Urological Association
Congress of Neurological Surgeons

Submitter : **Mr. Edward Dick** **Date: 08/21/2006**

Organization : **Edward Dick LCSW**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2275-Attach-1.DOC

#2275

Edward S. Dick LCSW, LICSW

NYS Lic# R027902

VT Lic#089-0000302

PO Box 101
Hoosick, NY 12089
518-265-1614

August 21, 2006

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

RE: File Code CMS-1512-PN

I am deeply troubled to learn of the proposed fee reductions for Social Work Services beginning in January, 2007. It is already a problem that fees are reimbursed at 50%, causing undo hardship to medicare recipients. This reduction will seriously affect my ability to accept medicare patients in an unrestricted fashion. I am an established private practitioner in a rural area which is underserved. This reduction will only make the problem worse.

Regarding the reduction in "Practice Expense Values", there has only been an increase in my expenses each year I have been in practice. This formula seems utterly ridiculous. Perhaps this could be exchanged with a reduction in expense values for the ongoing Iraq War our current administration has fostered. I request that you not approve the proposed ½ bottom up ½ formula to calculate practice expense and choose a formula which has some common sense and good judgement to it, one that doesn't penalize Clinical Social Workers.

I further request that you withdraw the proposed increase in evaluation and management codes until there are the funds to increase reimbursement for all Medicare Providers.

In conclusion I find it a sad affair that I even have to write this letter.

Truly,

Edward S. Dick LCSW

Submitter : **Dr. w. Michael Alberts** **Date: 08/21/2006**

Organization : **American College of Chest Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-2276-Attach-1.PDF

#2276

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August 21, 2006

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

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

American College of Chest Physicians Comments address: Evaluation and Management Codes, Critical Care Codes, CMS Budget Neutrality, SGR, Practice Expense Survey and Methodology

Dear Dr. McClellan:

I am submitting these comments on behalf of the American College of Chest Physicians (ACCP). The ACCP is comprised of over 16,500 physicians and allied health professionals, whose everyday practice involves diseases of the chest in the specialties of pulmonology, cardiology, thoracic and cardiovascular surgery, critical care medicine, sleep, and anesthesiology. These health care professionals practice in virtually every hospital in this country, and many of the physicians head major departments in these hospitals. As a multidisciplinary society, the ACCP offers broad viewpoints on matters of public health and clinical policy in cardiopulmonary medicine and surgery.

The ACCP appreciates the opportunity to submit comments for consideration on the CMS proposed rule regarding Medicare's proposed relative value units resulting from its third Five-Year Review, and proposed changes to the practice expense methodology affecting payments for CY 2007 published on June 29, 2006. We thank you for agreeing with the RUC recommendations for our five codes of interest.

3300 Dundee Road • Northbrook, Illinois 60062-2348 • USA
847/498-1400 *voice* • 847/498-5460 *fax* • accp@chestnet.org *e-mail*
www.chestnet.org

EVALUATION AND MANAGEMENT (E/M) CODES

ACCP was an active participant in the coalition of medical specialty societies and applauds the efforts of all physicians as part of this Five-Year Review process. We appreciate the acceptance by CMS of 100 percent of the RUC recommended E/M codes and support the physician work values developed through the RUC survey process for the Evaluation and Management codes. ACCP is in support of fully valuing the E/M codes for surgical global periods. We strongly believe that physicians should be paid for what they do.

CRITICAL CARE CODES, CPT 99291 and 99292

Although compelling evidence was not accepted on the critical care codes in the RUC process, physician work relative value units (RVU) were increased solely on the basis of rank order anomalies created by the other E/M increases. ACCP has participated in RUC surveys during each of the three Five-Year Reviews and each survey supported a value around 5.00 RVU. We are pleased with the proposed increase to 4.50 RVU for 99291, because we were given nothing the last two Five-Year Reviews, and believe our surveys more than support the value. We also agree that 99292, the each additional 30 minutes code, be increased to 2.25 RVU, calculated at half the value of 99291.

CMS BUDGET NEUTRALITY

Resulting from proposed increases to the physician work values of the Evaluation and Management codes in the Five-Year Review, CMS estimates a $4 billion increase in medical expenditures. Unfortunately, the law requires budget neutrality for both physician work and practice expense changes. ACCP is in strong disagreement with the proposed negative budget neutrality adjuster of 10% being applied by CMS to the MPFS physician work relative values. How can ACCP or any other medical specialty society easily communicate our great success with the Five-Year Review to our memberships, when the right hand giveth, and the left hand taketh away. By applying budget neutrality to physician work, this causes great confusion to non-Medicare payers who use the RBRVS payment system. ACCP strongly supports that the adjuster be applied to the conversion factor, which has historically been the way that CMS has adjusted for budget neutrality since 1996. This is the right thing to do, and it has historical precedent, and therefore, rescaling work RVUs would ignore increases in practice expense due to the increased RVUs. Because it is a relative scale, physician work changes have impacts on practice expenses and PLI. We know that physician work has changed for E/M services, and believe, that new monies should be infused into the physician fee schedule, just like new technology is supposed to add money to the program.

As quality performance measure initiatives move forward, we expect that there will be additional costs to physician practices to implement these new standards. We want to go on record to say that physicians and surgeons should be reimbursed for any additional costs to their practice.

SUSTAINABLE GROWTH RATE (SGR) FORMULA

In the recent past, Congress has intervened to put the SGR formula aside and mandate a Medicare conversion factor. Lobbying efforts have increased to prevent the proposed 5.1 percent decrease to the 2007 conversion factor (and 37 percent over the next nine years), and it is not clear if Congress will act before the November elections. ACCP still strongly believes that the SGR formula is seriously flawed and needs to be fixed. CMS continues to underestimate the

impact of National and Local Coverage Decisions on increased spending on physician services under Medicare. We need money added to the MPFS for all the ancillary costs associated with new preventive benefits being added for beneficiaries. We strongly support the removal of the costs of Medicare-covered physician-administered drugs from the SGR calculation. CMS needs to use its discretionary authority to remove the costs of Medicare-covered physician-administered drugs from the SGR calculation, which have increased from $1.8 billion in 1996 to $8.6 billion in 2004, and an estimated $8.2 billion in 2005. Nearly all of the medical community has commented on this issue and remains frustrated that the SGR-adjustment to the Medicare physician fee schedule has not been made.

MULTI-SPECIALTY PE SURVEY
ACCP has agreed to participate with AMA in the all-physician practice expense survey that will be conducted between April and December 2007. The multi-specialty survey is to be used as a basis to calculate indirect expenses (eg, heat/air, light, phones, office expenses). This survey replaces the AMA SMS survey for the calculation of pe/hr.

PRACTICE EXPENSE METHODOLOGY
Regarding practice expense, the ACCP supports the:

- Proposed methodology of the "bottom-up" approach that uses the best available refined data from the RUC and PERC deliberations for clinical labor, medical supplies and medical equipment in the calculation of direct practice expenses.
- Elimination of the non-physician work pool as proposed by CMS.
- Four year transition on the changes to the practice expense values, even though the proposed pulmonary impact is projected to be +2 percent.
- Proposed 50 percent equipment utilization rate.

PRACTICE EXPENSES REDUCED BY TWO-THIRDS (page 37250)
ACCP applauds the desire of CMS for transparency in the system. We were shocked to learn of the across-the-board re-pricing by a decrease of direct practice expense costs by two-thirds. For example, when the physician practice pays a salary to clinical staff based on the RN/RT blended labor rate of $0.47 per minute, CMS would only be reimbursing the practice two-thirds (0.667) of that, which calculates to be $0.31 per minute. Consider that this scenario further stresses an already diminishing health care workforce. This adds to decreasing practice reimbursements, onerous regulatory requirements and other third party payer requirements which are causing migration to the better paying opportunities, early retirement of physicians looking for more lucrative mid-life careers elsewhere.

DISCUSSION OF OTHER ISSUES
As a former rotating internal medicine member of the RUC, and as an active participant in the 2005 Five Year Review, the ACCP supports the RUC process.

The ACCP supports the existing RUC approved methodologies for estimating the intensity of physician services, including the elements of intra-operative time and post-operative visit patterns.

The ACCP also supports the use of valuable objective data from large clinical databases to

validate and confirm existing RUC methodologies, and we believe that there may be a larger role for the use of this type of information in future RUC valuations of physician work outside the scope of the Five Year Review process.

We believe, however, that it is important that the RUC establish processes for specific criteria to: validate large scale databases; verify the accuracy of these databases; apply the data derived to estimate the service intensity; and to assess the impact of incorporating such results into the RBRVS. We believe that it is also important that CMS agree with these RUC recommended processes. This would help to insure that the RUC recommendations would be included into the Medicare Physician Fee Schedule.

ACCP appreciates the opportunity to comment on the proposed rule under the Medicare Physician Fee Schedule. Should you or your staff have any questions, please do not hesitate to contact me, or Lynne Marcus at lmarcus@chestnet.org. Her telephone number is (847) 498-8331.

Sincerely,

W. Michael Alberts, MD, FCCP
President

Cc: ACCP Practice Management Committee
ACCP Government Relations Committee

Submitter : **Mr. Michael Ziskind** **Date: 08/21/2006**

Organization : **Centocor, Inc.**

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2278-Attach-1.DOC

#2278

August 21, 2006

By Electronic Delivery

Mark McClellan, M.D., Ph.D
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave. S.W.
Washington, DC 20201

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

Dear Dr. McClellan:

On behalf of Centocor, Inc., I am writing to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule published in the June 29, 2006 Federal Register at pages 37170-37430. Centocor appreciates this opportunity to comment on important aspects of the practice expense methodology, and looks forward to working with CMS to make appropriate adjustments in the CY 2007 physician fee schedule proposed rule to reflect its concerns.

As a leading biopharmaceutical company that discovers, acquires and markets innovative medicines and treatments that improve the quality of life of people around the world, Centocor believes in ensuring equitable and fair access to all necessary medicines for all patients. Among other life-improving medicines,[1] Centocor manufactures Remicade®, a product used by patients who suffer from the debilitating effects of rheumatoid arthritis, Crohn's disease, ankylosing spondylitis, psoriatic arthritis, and ulcerative colitis, enabling these individuals to enjoy longer, more productive lives. Rheumatoid arthritis is a chronic disease that attacks the body's joints, causing inflammation, tissue destruction, and joint erosion. It affects over two million Americans, many of whom are Medicare beneficiaries. Each year, an additional 50,000 Americans are diagnosed with rheumatoid arthritis. Crohn's disease and ulcerative colitis are relatively rare conditions, causing inflammatory disease of the intestine with symptoms that include diarrhea, severe abdominal pain, fever, chills, nausea and, specifically in the case of Crohn's disease, fistulae.[2] Without proper treatment, the pain associated with these diseases can severely impact the quality of life of afflicted individuals.

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[1] Centocor also manufactures ReoPro® for acute coronary care.

[2] Fistulae are painful, draining abnormal passages between the bowel and surrounding skin.

Although rheumatoid arthritis, Crohn's disease, ankylosing spondylitis, psoriatic arthritis, and ulcerative colitis are chronic and debilitating conditions, Remicade® is a highly effective treatment that can slow the progression of these diseases and significantly enhance the quality of patients' lives by reducing their pain and other incapacitating conditions. Because Remicade® cannot be self-administered by patients, the Medicare Program provides Part B coverage for this infused therapy both in the hospital outpatient department and physician office settings. Thousands of Medicare beneficiaries afflicted with these conditions rely on Remicade® and other medications to manage their conditions and improve the quality of their lives.

Proposed Change to Drug Administration Practice Expense Relative Value Units (RVUs)

Remicade® is a monoclonal antibody that is administered by intravenous (IV) infusion and generally takes about two hours to infuse. Thus, its administration is billed using Current Procedural Terminology (CPT) code 96413 (Chemotherapy Administration, IV Infusion, 1st Hour) and CPT code 96415 (Chemotherapy Administration, IV Infusion, Each Additional Hour). In the proposed rule, the practice expense RVUs would decline from 2006 to 2007 by 3.1 percent and 3.9 percent, respectively, for codes 96413 and 96415. If the reductions were to go forward and be fully phased-in as proposed, they would be 11.8 percent and 10.7 percent, respectively, by 2010.

In the proposed rule, CMS indicated it was proposing the "bottom-up" methodology to calculate the direct practice expenses included in the RVUs because it believes the proposed methodology would be more intuitive and result in fewer situations than the current methodology where changes affecting one code have unanticipated effects on other codes. Centocor shares the goal of a more understandable and predictable physician payment system. However, these drug administration codes have already undergone extensive review and revisions over the past several years. We are concerned that these proposed reductions, particularly combined with the proposed payment reductions due to the sustainable growth rate (SGR) formula, will lead to underpayment for these services, potentially resulting in more limited access to important therapies like Remicade®.

Drug Administration Codes Should Not be Revised Under the New Methodology

The Medicare Modernization Act of 2003 (MMA) required CMS to make a number of changes to its policies surrounding payments for drug administration. First, it required the inclusion of practice expense per hour survey data that was collected by the American Society of Clinical Oncologists (ASCO). Second, the MMA required CMS to ensure the drug administration CPT codes take into account, among other things, the complexity of the administration and the resource consumption of these codes. As a result, CMS implemented new codes that allowed the administration of Remicade® to be billed under the codes associated with administration of chemotherapy. The new codes also reflected updated direct practice expense

input data approved by the American Medical Association's (AMA) Relative Value Update Committee (RUC).

Contrary to the MMA requirement, CMS' proposed methodology would no longer use the ASCO survey data for direct practice expenses. In addition, by proposing to reduce payments for these services below the current amount that reflects the changes mandated by the MMA, CMS is violating Congressional intent to ensure continued full access. **Therefore, we urge CMS to exclude these drug administration codes from the proposed changes to the practice expense methodology until CMS makes the changes noted below.**

Last year CMS proposed to exclude these codes from the methodology changes when it proposed to move to a bottom-up methodology. Although the reason given at the time was that CMS did not have accurate utilization data corresponding to the new codes (which it now has), we believe a more compelling reason to exclude these data is that the current RVUs reflect Congressional intent and the concerted efforts of the AMA, CMS, and many other stakeholders to comply with that intent.

In addition, the MMA required the Medicare Payment Advisory Commission (MedPAC) to conduct two studies on the effect of the MMA's drug administration payment changes on the quality of care furnished to beneficiaries and the adequacy of reimbursement. In January 2006, MedPAC issued the first of these reports, which focused on services provided by oncologists. MedPAC concluded that it was difficult to assess the impact of the payment changes on physicians' practices because the MMA provided for additional transitional payments for two years and CMS made additional payments available to oncologists through its quality-of-life demonstration project. MedPAC's second report, due in January 2007, will focus on drug administration services provided by other specialties. Because the impacts on beneficiary access to care have not been fully analyzed at this point, we urge CMS to postpone any cuts in payment until it can confirm that the new rates will allow physicians to continue to provide vital drug and biological therapies to Medicare beneficiaries.

Pharmacy Management Costs Should be Fully Recognized

The current payments fail to adequately recognize all of the costs associated with handling pharmaceuticals. These costs are related to storage space, preparation, inventory management, quality assurance, and environmental and safety measures related to disposal of unused medications. In its June 2005 Report to Congress, MedPAC found that 26 to 28 percent of costs related to hospital pharmacy management are attributable to factors other than acquisition costs.[3] This suggests that physicians may have substantial uncompensated expenses associated with pharmacy management for complex biologics as well.

Although the RUC did include some pharmacy preparation and physician supervision in the direct practice expense inputs for the new drug administration codes, it is not sufficient to cover all of physicians' pharmacy management costs. The proposed reduction of the practice

[3] Medicare Payment Advisory Commission, "Report to the Congress: Issues in a Modernized Medicare Program", June 2005, 141.

expense RVUs for these codes would result in further underpayment. **Therefore, CMS should exclude the drug administration codes from the bottom-up calculation of practice expense RVUs until it establishes new codes to recognize pharmacy management costs.**

Prolonged Physician Services Should be Compensated

Physicians caring for medically-complex patients often spend extended time managing the disease apart from direct patient encounters for which they are not compensated. For example, developing treatment plans for patients receiving chemotherapy (including complex biologics such as monoclonal antibodies) requires additional attention and consumes additional resources that are not captured in the current chemotherapy infusion codes or the evaluation and management (E&M) codes recognized by Medicare. Other activities include consulting with other professionals involved in treating these patients and answering questions from the patients and their families.

Currently, Medicare does not pay separately for prolonged physician services without direct patient contact, despite the existence of CPT codes 99358 and 99359, Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact for chemotherapy patients. Medicare considers these services to be bundled into other E&M codes (70 FR 70459)

The work and practice expense inputs associated with codes 99358 and 99359 were approved by the RUC and represent costs that are not associated with other E&M codes. In fact, many other payers currently use these codes to compensate physicians for prolonged services in addition to direct, face-to-face, patient services. **We believe all physicians should be fully compensated by Medicare for providing these services, particularly in the management of chronic diseases. This would be entirely consistent with the movement to align Medicare's payments with improved quality of care.[4] However, as a first step, CMS should activate these codes for patients receiving complex therapies, the administration of which is described by CPT codes 96401 through 96417.**

This step should be taken regardless of whether CMS includes the drug administration codes in its proposal to revise the calculation of practice expense RVUs. But it is critically important to take this step should CMS elect to revise the drug administration practice expense RVUs as proposed. Otherwise the agency will be taking the risk of impeding patient access to these services, as described above.

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[4] In the June 21, 2006 press release accompanying the proposed rule, Administrator Mark McClellan states, "We expect that improved payments for evaluation and management services will result in better outcomes, because physicians will get financial support for giving patients the help they need to manage illnesses more effectively."

Indirect Practice Expenses

As described in the proposed rule, the source data for indirect practice expenses are either the AMA's Socioeconomic Monitoring Survey (SMS) data from 1999, or more recent data for specialties that voluntarily undertook a survey in order to update the 1999 SMS data. These data would continue to be the source data for indirect practice expenses under the proposed bottom-up methodology. CMS describes several options for updating these data, including continuing to accept supplemental survey data or an SMS-type survey of only indirect costs for all specialties.

To achieve CMS' goal to make the practice expense RVU calculation fair and predictable, it is critical to update the indirect expenses for all specialties in a consistent manner. This should be a top priority, given the high percentage of overall practice expenses attributable to indirect costs. **We recommend that CMS delay the implementation of the bottom-up methodology until it has received updated and consistent indirect practice expense data for all specialties. If implementation cannot be delayed entirely, we recommend that, until the indirect practice expense data are updated, the implementation of the proposed methodology should go no further than the second year of the scheduled phase-in, with 50 percent of practice expense RVUs calculated using the current methodology and 50 percent of practice expense RVUs calculated using the bottom-up methodology.**

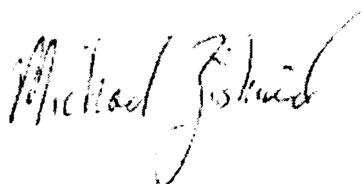
For example, the proposed rule states the practice expense RVUs calculated using the bottom-up methodology would be phased in over four years as follows: 25 percent during CY 2007; 50 percent during CY 2008; 75 percent during CY 2009; and 100 percent during 2010 and thereafter. Under this recommendation, the blend of the current methodology and the bottom-up methodology would remain at 50 percent each until the indirect practice expense survey data were updated for all specialties.

Summary and Recommendations

We applaud CMS's efforts to develop a new methodology that better recognizes actual practice expense consumption. However, due to the special consideration Congress gave to drug administration services in the MMA, we believe these codes should be excluded from this proposed change. This is particularly important given the potential for a 5.1 percent payment reduction resulting from the SGR formula. At a minimum, CMS should exclude these drug administration codes from the bottom-up methodology until it has enacted changes to fully compensate physicians for their pharmacy handling and overhead costs, as well as their prolonged services costs for managing their patients' illnesses. Furthermore, CMS should not move to full implementation of the bottom-up methodology until it has received updated indirect practice expense data for all specialties.

I appreciate the opportunity to comment upon the important issues raised by this proposed rule, and look forward to working with the agency to ensure that the methodology appearing in the final rule is implemented in an equitable manner that preserves beneficiaries' access to quality health care under the Medicare Program. Please contact us if you have any questions about this matter.

Sincerely,



Michael Ziskind
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Horsham, PA 19044
phone: 610.651.6000
fax: 610.651.6100

Submitter : **Mr. James Hugh III MHA** **Date: 08/21/2006**

Organization : **AMAC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-2279-Attach-1.DOC

#2279

A
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A
C

Your
Prescription
for Data
Management
and Financial
Success

August 21, 2006

Mark McClellan, MD, Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8018

Re: CMS 1512-PN; PRACTICE EXPENSE

Dear Dr. McClellan:

AMAC® performs billing and consulting services with more than 800 cancers center nation wide both hospital and freestanding. We work with providers and act as a liaison to third party payors. Since the advent of the RBRVS in 1992 there has always been inadequate payment for freestanding centers. In 1991, at a meeting in Washington D.C., I asked Dr. Hsaio why the technical component was not addressed in the study and his statement was, "the government did not pay me". For the last fourteen years the Medicare payment rates have not been corrected and freestanding centers practice expense for the technical services has been severely undervalued.

The increase in the practice expense in most of the radiation oncology codes in the proposed rule is a good beginning with the exception of the following codes:

77336 – Weekly physics
77295 – 3-D simulation Physics planning
77300 – Dosimetry calculations
77370 – Special physics consult
77315 – 2-D complex teletherapy isodose planning

As physicists and dosimetrists salaries have almost doubled in the past 5 years these reductions would severely impact the hiring of competent and qualified medical physicists that represent the above CPT codes. We implore CMS to reevaluate the above codes.

The societies that we at AMAC® work with have sent in letters addressing a number of items in detail and we support all of those by AFROC, AAPM and ASTRO.

Sincerely yours,

James E. Hugh III, MHA, CHBME, ROCC®
Senior Vice President
AMAC®

AMAC®
P.O. Box 72543 • Marietta, GA 30007-2543
Phone: (770) 693-6031 • Fax: (770) 693-6030 • www.amac-usa.com

Submitter : **Dr. Clifford Hallam** **Date: 08/21/2006**

Organization : **The Care Group, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment by The Care Group re: Pracie Expense and Budget Neutrality Proposal

CMS-1512-PN-2281-Attach-1.DOC

#2281

August 21, 2006

Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS Comments regarding 1512 Proposed Notice: 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)

Dear Dr. McClellan:

The Care Group is a practice that sees 354,331 patients each year in the greater Indianapolis area, our 134 physicians and 760 employees appreciate 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 Practice expense (PE) Methodology and the Five-Year Review of Work RVUs under the Physician Fee Schedule.

Comments regarding Proposed changes to the Practice Expense Methodology:
The Care Group 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 physician's 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.

The estimate of direct costs is a 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.

An example of some many flaws contained in the RUC determined direct cost estimate would be the assumed use of wound closure devices, which significantly reduces staff post-procedure time. However, the cost of such devices were not taken into consideration. In addition, many labs such as ours, do not use such devices, which results in a significant increase in labor and facility-related costs.

Budget Neutrality:

We would urge CMS to reconsider the current proposals. A 10 percent reduction across the board to physician work RVU would cause increased confusion to payors, who also use CMS RVUs as a basis for payment. This does not seem consistent with CMS' goal of cost transparency.

At the same time, the RUC has worked hard to value physician work accurately. An across the board reduction devalues physician work. Reducing the work RVUs hurts services that derive most of their value from physician work – for example, E&M services, interventional cardiology, EP procedures, and hospital-based services.

General Comments:

We remain concerned that even after spending what feels like an extensive amount of time reviewing the proposals – we still may not adequately understand the rationale for shifting to the new payment methodologies at this time and how this relates to other proposals such as the DRA and the comparison of the physician technical fees to hospital out patient fees.

It seems that certain services such as imaging (nuclear, and echo) as well as procedures such as cardiac catheterizations for example might be in jeopardy of an unintended multiple reduction due to the PE and DRA provisions.

In an effort to identify and facilitate a more accurate methodology we will continue to provide feedback and data to our professional societies such as ACC, COCA, CAA, and SCAI.

We note that CMS has acknowledged in the proposed rule that only two-thirds of the direct expenses are recognized due to budget constraints. Physicians are under budget constraints as well and cannot continue to absorb these under-valuations especially with the predications of a 37% pay cut over the next nine years.

Indiana is considered a National "Hot Bed" for Pay for Performance and we would note that as with HIPAA, we have identified additional significant costs in order to engage in

the quality improvement activities that CMS and other payors have been advocating. While we welcome the concepts of P4P – it is difficult to add more expenses when Medicare physician payments are not keeping up with medical practice costs.

The Care Group, LLC physicians would like to thank you for the opportunity to comment on the proposed Rule. The Care Group LLC appreciates CMS' continued willingness to reach out and work cooperatively with the physician community.

If you have any questions regarding these comments, please feel free to contact Lana Lehman, Executive Vice President or myself at 317.338.6051.

Sincerely,

Clifford C. Hallam, M.D.
Managing Partner and CEO

The Care Group, LLC
8333 Naab Road, Suite 400
Indianapolis, IN 46260

Submitter : **Mr. Brad Cavanagh, MSW, LCSW** **Date: 08/21/2006**

Organization : **Mr. Brad Cavanagh, MSW, LCSW**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2283-Attach-1.DOC

CMS-1512-PN-2283-Attach-2.DOC

ATTACHMENT 1
#2283

August 21, 2006

RE: File Code CMS-1512-PN, PUBLIC COMMENT

Dear CMS representatives,

I am writing in response to the proposed 14% reduction in fees paid to licensed clinical social workers, outlined in file code CMS-1512-PN. I am a LCSW, and I work with elderly clients in the mental health field. The fee reduction proposed by CMS would make it impossible for me and other licensed mental health professionals like me to continue providing much-needed therapy services to the seniors who need it most.

I am not sure of the reason for the proposal to reduce fees, but I want to emphatically state that licensed clinical social workers and other mental health professionals who work with seniors are not rich people. All of the professionals I know have to work a full week, and then some, to pay the bills for their own families in these difficult economic times.

As you know, Medicare already only pays one-half of the designated rate for one hour of psychotherapy, and only pays for face-to-face contact. This leaves it up to the therapist to make the timely effort of chasing secondary insurance policies for reimbursement. If the client has only Medicaid as a secondary policy, then there is absolutely no other reimbursement aside from billing the client, who already has limited financial resources. The Medicare rate does not include time for traveling to seniors, who often cannot leave their homes or nursing facilities; it does not include time for documentation; and it does not include time for collaborating with the family, physicians, nursing facility staff, and other important people that make up the team of people caring for an elderly individual. These "non-face-to-face" activities all require a significant amount of time that is not covered under the current Medicare rate. If this rate is cut per the current proposal, so many seniors will not receive mental health services they so desperately need.

Given the facts outlined thus far, I sincerely request the following:

- Please do not reduce the work values for clinical social workers by 7% on January 1, 2007; and do not reduce the total work values by 14% by 2010.
- Please withdraw the proposed increase in evaluation and management codes until CMS has the funds to increase reimbursement for all Medicare providers.
- Please do not approve the proposed "Top Down" formula to calculate practice expense. Please select a formula that does not create a negative impact for mental health providers or seniors we serve.

Please do the right thing for the seniors of the United States. Thank you.

Sincerely,

Brad Cavanagh, MSW, LCSW
St. Louis, MO

ATTACHMENT 2
#2283

August 21, 2006

RE: File Code CMS-1512-PN, PUBLIC COMMENT

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Sincerely,

Brad Cavanagh, MSW, LCSW
St. Louis, MO