**Submitter :** Dr. G Michael Vincent **Date:** 07/10/2006

**Organization :** Dr. G Michael Vincent

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Thank you for reviewing this issue. I have been a Chair of a large Department of Medicine for 31 years, and simultaneously was the Director of an Internal Medicine Residency for 26 years and a Transitional Year Residency for 19 years. I have witnessed our brightest medical students progressively opt for anesthesia, radiology, ophthmology, dermatology, etc, fields with fixed hours, high pay, and little night and weekend call, while primary care fields (with much lower pay, and substantial weekend and night call) have declined and as you know are threatened with too few applicants to meet the needs of our patients. The American College of Physicians have issued major warnings about the decline and fall of Internal Medicine as a discipline, and Family Practice and Pediatrics are concerned as well by falling applicants. We can't fill the needed training slots with American physicians due to lack of interest.

The disparity of reimbursement between the the primary care specialties and the subspecialties, particularly the procedure oriented ones, is dramatic and destructive to the field of medicine and dangerous to the welfare of patients in general. As a Department Chair I have recognized up to 4-6 fold differences in annual incomes between some full practice internists and certain procedure oriented subspecialties. This is wrong. In my own case as a cardiologist, my hourly income while doing invasive procedures was about 6-8X greater than when doing comprehensive and complex, referral based E & M work.

The consequences of the current, seriously flawed, system are very dangerous to our health and our pocketbooks, and include the following:
1. Extraordinarily high priced medical care. Industry and physicians progressively develop and seek very high priced interventions, gismos and gadgets to treat established disease that could have been modified or even prevented if there had been incentive to spend as much energy and time developing these processes as has been done on mechanical and other interventions. One simple example is the exploding area of heart failure, most of which is caused by hypertension, lipidemia, smoking, etc, and coronary artery disease. We could certainly save money and markedly improve health care if we paid physicians much more to agressively remediate these avoidable risk factors and prevent and/or limit these diseases, rather than provide a small fee for management then spend exceptional amounts on stents, CABG, ICDs, LVADs, etc, with their substantial morbidity and recurring costs. What if we paid the internist and office based cardiologist the same amount per hour of work as we do the interventional cardiologist or cardiac surgeon? I propose we would see a dramatic change in behavior, a great improvement in health,and overall lower costs. How about paying the internist or office based cardiologist more per hour work than the interventionalist? Probably an earth shattering improvement in care.
2. Fewer top medical students entering the primary care and other lower paying fields.
3. Many more harmful, adverse events in patients due to the high volume of interventions, some with borderline to absent indications.

I congratulate you for reviewing this mess, and strongly encourage you to review the work relative value units and markedly improve the reimbursement for physicians who provide detailed and well thought out E & M care for patients, such that income is not the driving force for physician decisions, either about their career choice or their treatment strategies.

**Submitter :** Dr. Daniel Kimball, Jr. **Date:** 07/10/2006

**Organization :** Hospice St. John of Greater Berks Area

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a Hematologist/Oncologist who practices part time as a Medical Director of a regional Hospice. I spent most of my career training Residents in general internal medicine to practice primary care or go into further training for a subspecialty. The primary care practitioners in my area are having such a problem meeting their practice expenses that their incomes have become marginal. They have appealed to the hospital to employ them as primary care practitioners and to run their practices for them and pay their office staff and pay their overhead expenses. I strongly endorse the proposed rulemaking which would increase the work relative value units assigned to office and hospital visits and consultations for primary care physicians. I urge CMS to finalize the recommended work RVU increases for evaluation and management services. I feel that these changes will increase the likelihood that we can attract internal medicine residents to remain in primary care as opposed to automatically going to a specialty where they feel they are more likely to earn a living that will pay off their medical school debts. I would also urge CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.
Thank you for the opportunity to submit these comments.

**Submitter :** Dr. Charles Halliburton **Date:** 07/10/2006

**Organization :** Lake Primary Care Physicians

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I strongly support increasing the WRVU value for outpatient and inpatient E/M services. This is necessary to maintain enough physicians willing to provide complex intellectual services to an increasingly complex patient population. This will help us to spend the time necessary to evaluate and manage complex patients. Currently, the system does not reward physicians for spending much time with an individual patient or making complex management decisions. The current payment system is luring physicians in training to procedure oriented types of practice with less patient management responsibility. It is encouraging physicians who do this type of work to retire as soon as possible - it is very stressful to see 20 - 30 complex patients a day as is now necessary to meet productivity requirements. If this continues, I can only anticipate a vacuum in primary care and increasing fragmentation in the way healthcare is delivered in the U.S. along with overutilization of expensive technology without improvements in health outcomes.

**CMS-1512-PN-352** **Five Year Review of Work Relative Value Units Under the Physician Fee Schedule**

**Submitter :** Dr. Sima Desai **Date & Time:** 07/10/2006

**Organization :** Oregon Health & Science University

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1512-PN-352-Attach-1.DOC

#352

*Where Healing, Teaching and Discovery Come Together*

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HEATHER K. CROWELL
HOSPITALIST ASSISTANT

July 10, 2006

Dear CMS,

As a general internist I am urging you to finalize the recommended work RVU increases for evaluation and management services.

I have been practicing for over 8 years in my field and I have seen an exponential growth in the amount required to diligently care for patients outside of their visits. As general internist we coordinate not only with our patients and their families but other caring providers ranging from subspecialty physicians, case managers, therapist, nurses and entities such as hospice, nursing homes, foster homes, etc. We do not have procedures that will pay and account for the large amount of time we spend caring for our patients. Coordination of care is the general internist's "procedure"; thus, accounting for this time and effort is crucial for the survival of general internal medicine and other primary medicine specialties. More and more medical students are electing to go into subspecialties or other fields in which procedures bring in a large part of their income and in turn the number of students going into general internal medicine and other primary care specialties is taking the steepest downward spiral. In the end, who will be left to do the most important care of coordinating with the number of subspecialty providers patients have these days and putting together the complexities of medicine in this era?

By making this change permanent, you are sending a strong message to patients and physicians that the work the primary care specialists do is important and should be compensated for. This in turn will allow access to primary care for patients. At the rate we are going there will be no one left to do the work of the primary care physician and thus patients will suffer the most. I urge you to reject any comments that would allow the lowering of the overall improvements in work RVUs for E/M services.

Sincerely,
Sima Desai MD
Associate Professor of Medicine
Oregon Health & Science University

**Submitter :** Dr. lee mckinley **Date:** 07/10/2006

**Organization :** bloomington hospital

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I support a review of reimbursement policies for e&m services. I am an Internist entering the last 10 years of practice and we currently have a shortage of 26 Internists in our community. We cannot recruit them for office practice because the practice will not support itself financially and no one will subsidize it any longer. My own parent's MD has stopped seeing Medicare patients due to decreasing income. Take a look at the stats on Medicare patients who have no primary MD, it is very high.They are receiving episodic care thru the emergency rooms. Thanks for listening.

**Submitter :** Dr. Thomas Cooney **Date:** 07/10/2006

**Organization :** OHSU

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I am writing to urge CMS to finalize the recommended work RVU increases for evaluation and management services.

I am a Professor of Internal medicine and a general internist. I have directed an internal medicine training program for over 20 years and have received extensive feedback from my graduates regarding the adverse effects the current RVU system has had on their practices and have witnessed a distressing decline in the percentage of graduates entering the practice of general internal medicine, driven in large part by the poor remuneration for E+M services.

The complexity and work associated with taking care of patients during office and hospital visits has increased dramatically during the past ten years. The scope of preventive services, including patient education and chronic illness managment in the outpatient setting and mutisystem disease and multidisciplinary team coordination in the fast paced inpatient setting have increased dramatically the work demands on general internists.

In the absence of this overdue correction to the RVU system for E+M services, I believe we will face a rapid decline in the availability of primary care physicians and and paradoxically a dramatic increase in health care costs due to fragmentation and overutilization of specialty services. Changing the RVU system is a critical step in assureing continued access to primary care services.

Candidly, I expect CMS to receive intense pressure from specialty physicians and societies, particularly those who are procedurally oriented, to reduce or even eliminate this much needed improvement to the E+M RVU system. I urge CMS to reject any such proposals and to implement the current proposed system.

**Submitter :** **Dr. Rebecca Quiroz** **Date: 07/10/2006**

**Organization :** **Quiroz Adult Medicine Clinic**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I would like to express my support for the proposed increase in the work relative value units (RVUs) assigned to office and hospital visits and consultations. As an internist in a solo practice, this proposed increase will help to assure that I can stay in practice.

**Submitter :** Dr. Peter Sullivan **Date:** 07/10/2006

**Organization :** Oregon Health Sciences University

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

As an academic internist who has been working at a major teaching hospital for the past 12 years, I wish to encourage the adoption of the updated RVU values. The medical complexity of my patients has increased markedly during this time period, and the time spent in managing the multitude of complicated issues is not currently reimbursed at a fair level.

**Submitter :** **Dr. leon driss** **Date: 07/11/2006**

**Organization :** **Dr. leon driss**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

It is long over due to increase physician reimbursement for office visit and hospital visit e/m codes. I am a general intertist. I take care of the sickest of the elderly. I am not surprised that few medical students want to become a general internist. We care for the sickest patients, have some of the longest working days, hardest call and yet compared to reimbursement for simple procedures like reading an echo or freezing a skin lesion we are reimbursed less. Most surgeons can be reimbursed for one procedure more than an internist can be reimbursed for an entire busy day seeing pts. Increasing the reimbursement for cognitive instead of procedural activities is one late step in the right direction. But it may be too late. The general internists who shoulder the burden of caring for the sickest of the elderly population are burned out and retirering. New medical students are not fools and want little to do with this under paid over worked specialty. Yet general internists are the only specialty equipped to manage the diversity of problems of the elderly and do so without providing a highly reimbursed procedure to each patient as our specialty comrades do intentionally or not saving the government money in the process. Act now before it is too late. I for one will begin to restrict new medicare patients to my practice if the reimbursement for my activities caring for medicare patients begins to drop.

**Submitter :** **Dr. George Meyer** **Date: 07/11/2006**

**Organization :** **Dr. George Meyer**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I support the proposed increase in the work relative value units (RVUs) assigned to office and hospital visits and consultations, known as evaluation and management (E/M) services.

**Submitter :** Joseph Pilewski **Date:** 07/11/2006

**Organization :** Joseph Pilewski

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please approve as final the changes in RVU system. As an internist and pulmonary specialist, I care for patients with chronic lung diseases, including cystic fibrosis and lung transplantation. These patients are generally young and, due to detailed and time consuming health care, remain productive members of society. Managing their multiple medical problems and complex medications, including antibiotics and immunosuppressive drugs, is terribly time consuming and not reimbursed adequately under the current system. Patients require frequent phone contacts and data review outside of their regularly scheduled appointments. If we are to make optimal use of the advances in medical care for this deserving population, a permanent adjustment to the RVU system is highly appropriate.

Thank you for your consideration.

**Submitter :** Dr. Lynne Goebel **Date:** 07/11/2006

**Organization :** American College of Physicians, Marshall Univ.

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I am pleased that CMS is considering an increase in work RVU's for internists. I hope that this will encourage more students to pursue primary care as a career. Most students have large debts and tend to let that burden guide their choice of specialty. The increase in RVU's for internists will help in letting students know that their expertise as primary care physicians is appreciated and necessary for the medical system to survive.

**Submitter :** **Dr. Daniel Mangum** **Date: 07/11/2006**

**Organization :** **Dr. Daniel Mangum**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

This letter is written in support of the proposed increase in Evaluation and Management Relative Value Units currently under review and discussion.

I am a board certified Internal Medicine specialist in private practice for the past 15 years. I have debated whether I can continue to provide primary medical care to the elderly for many of these years. Ultimately I have maintained some access but only out of empathy to my established patients and their families, as well as my own personal and professional obligation to provide this care. It most certainly has not been due to this being a good business decision as many colleagues have pointed out and who have elected to drop Medicare patients. Those associates, and my accountant, have made it clear to me that I am making less money despite working harder&a fact that I admit becomes difficult to swallow.

An increase in RVU rates is long overdue and failure to raise these rates will only widen the gap of compensation which most certainly will lead to fewer primary care physicians participating and providing care to an ever growing elderly population.

Sincerely,

Daniel K. Mangum DO FACP
Chair, Oregon Health Services Commission
Portland, Oregon

**Submitter :** **Dr. Susan Escudier** **Date: 07/11/2006**

**Organization :** **Texas Oncology, PA**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I would like to express my support for a proposed increase in the work relative value units (RVUs) assigned to office and hospital visits and consultations, known as evaluation and management (E/M) services. I urge CMs to finalize the recommended work RVU increases for evaluation and management codes.

In my practice of hematology and medical oncology, a typical visit consists of review of cancer and treatment symptoms, reiew of medications and side effects, an examination, ordering and interpretation of laboratory and radiolgy studies, planning of treatment, managing of home health care and discussion of prognosis and long term planning. This is on top of a mountain of paper work to please the insurance company, corresponding with other physicians and patient employers. Internal medicine and specialities are underpaid for the work and cognitive abilities required to provide patient care.

Since many private health plans use the Medicare-approved RVUs for determining their own fee schedules, the increases proposed by CMS are also likely to increase non-Medicare payments to internists. Such redistribution will begin to correct long-standing reimbursement disparities that are contributing to the looming crisis in access to primary care and help ensure an adequate supply of internists and other physicians to care for an increasingly aging population.

Many of my colleagues are taking early retirement due to the economic pressures of medical practice.

Thank you for your time.

**Submitter :** Dr. Rick Frieden **Date:** 07/11/2006

**Organization :** Enloe Primary Physician Group

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I would simply like to say what general internists, pediatricians, and other non-procedure-based physicians have been saying for a long time: The RVU system as it is presently constructed GROSSLY undervalues the worth of mind-work (office and hospital visits, for example) relative to the value of procedures. This disparity needs to be changed.

I am a hospital-based internist and neurologist. The patients I see are complex and difficult. Most of them have multiple simultaneous active chronic disease processes, and often present with more than one acute problem as well. Their proper care requires careful consideration of each and every medication and dose, each and every lab test, each and every diagnostic procedure, etc. Manipulation of any part of their physiology affects all the other parts - they are fragile and have no physiologic reserve in many cases.

What I do for patients requires as much expertise, experience, and judgement (and is no less difficult or dangerous) as an interventional cardiologist, a surgeon of any stripe, or any other procedure-based physician does. If I make a mistake, the consequences for the patient are equally disastrous. It is more difficult to measure because much of what I do is in my head. It is difficult and extremely time-consuming - if not impossible - to clearly document the work I do because most of it either occurs in my head or in my interactions with my patients. It is by its nature intangible. That does not make it of less value, however. The RVU system needs to be changed to reflect the true value and importance of what I do.

**Submitter :** Dr. Mark Capriolo **Date:** 07/11/2006

**Organization :** Ministry Medical Group - Weston

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

An adjustment in WRVUs is long overdue and over the long term vital for the public health system as a whole. Largely because of poor reimbursement for primary care providers coupled with high debt loads of physicians coming out of training, fewer are pursuing a career in primary care for financial reasons. Poor reimbursement leaves one under that debt load for far too long a time. The temptation to train for a career in a high paying speciality is too great for many. The looming shortage in primary care providers has been well documented. Unless more individuals can be enticed into primary care, the system will implode and fail. The first step in avoiding this problem is to make it clear to doctors in training that a primary care career is financially competitive with other career choices in medicine. Also, Specialists, for a variety of reasons, do not want and will not be able to manage complex patients with multiple medical problems spanning multiple specialities, all with complex medication regimens. Internal Medicine physicians and some Family Medicine doctors fill this niche, providing the expertise to manage these complex patient problems. These cases require provider skills and TIME, not technology and it is appropriate to compensate this expertise fairly. E&M reimbursement formula need to recognize that great value can be delivered to patients without the use of a scalpel, catheter, or endoscope. In addition, patients consistently state they value very highly the TIME they spend with their doctor, yet this has been consistently undervalued by previous RVUs. The proposed changes in WRVUs provide an opportunity to address multiple problems in the health care delivery system; I sincerely hope they will be implemented.

**Submitter :** **Dr. Douglas Hegstad** **Date: 07/11/2006**

**Organization :** **Riverside Faculty Medical Group**

**Category :** **Physician**

**Issue Areas/Comments**

**Other Issues**

Other Issues

I am a general internist. I graduated from Medical School in 1980. I got through medical school on loans and had an accrued debt of $20,000. As a resident, I earned $24,000 per year. My wife, a nurse, earned $29,000 per year.

We bought a 2,000 square foot house in Loma Linda, CA, for $59,000.

Medical Students now graduating have an accrued debt of $200,000. The 2,000 square foot house in Loma Linda now sells for $500,000. A resident makes about $30,000 per year.

When I graduated in 1980, internal medicine and other fields with high E&M were not the best compensated, but they were compensated well enough that it was possible to purchase a home and pay off loans.

In 2006, things have changed. The income gap between E&M heavy specialties and procedure specialties has grown. Student debt load has grown. Income potential has not matched the 8-fold increase in home prices. Students must consider the economics of practice more than ever.

If the aging population is to have sensible care, it must have primary physicians to provide that care. Medicare has tremendous power to influence the economics of practice--and the economics drive career choices more than ever.

As head of a practice group, I sign many contracts with the phrase, 'Group will provide services for $ [multiple] of Medicare payments for that service.'

When Medicare payments get out of balance, they reverberate throughout the healthcare system. They distort the mix of physicians available to provide care.

Please implement the proposed increase in the work relative value units (RVUs) assigned to office and hospital visits and consultations for E&M services.

Douglas Hegstad, MD

**Submitter :** Dr. steve towner **Date:** 07/11/2006

**Organization :** IHC

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I have been in Primary care internal medicine for 20 years. I am heavily involved in quality assurance programs and actively teach in the medical school. I have always recommended internal medicine as a great career choice, until the last year or so.

My workload is continually escalating with increasingly burdensome paperwork and non-patient care issues. My income has fallen dramatically relative to inflation and the complexity of problems that we are dealing with is escalating. I feel that for patients with chronic diseases, careful internal medicine care is absolutely critical. Instead we receive incentives to do procedures on people and order tests.

Many patients have multiple chronic diseases and are on multiple medications that require considerable thought and monitoring. At visits they almost always have multiple other questions that could easily consume the entire allotted time. There is no incentive for taking the extra time to monitor these chronic diseases or offer preventative services other than the conscience of the doctor. In my quality role I often see how poorly these issues are managed by physicians whose patient's think they are wonderful.

We need to provide incentive to care for patients with chronic diseases preferably including some outcomes data. When students ask me about a specialty choice, I now suggest something that has a procedure associated with it. How crazy is that?

**Submitter :** **Dr. stewart Shankel** **Date: 07/11/2006**

**Organization :** **Univ. of California Riverside**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am writing in support of the proposed E/M changes. Primary care, especially internal medicine is the backbone of much orf the primary care in the US. The work is hard and time consuming to diagnose and to treat effictivelly the difficult problems internists are faced with day after day. The pay has been so poor and the work hard and many new physicians are opting to go into other fields of medicine. We cannot afford to lose our interists or the practice of medicine will suffer a great deal I urge you to finalize the recommended work RVU increases for evaluation and management as soon as possible.
Residency matching in the last few lyears has shown a marked trend away from the primary care specialties. Your prompt response to this bill will hopefully change this hemorrhaging away from internal medicine.
sincerely
Stewart Shankel M.D. FACP

**Submitter :** Dr. Brinton Clark **Date:** 07/11/2006

**Organization :** Providence Portland Medical Center

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

The proposed changes to increase the RVU values for E&M services are critical to increasing the interest in primary care careers. Our nation currently faces a crisis of diminishing primary care providers. Unless re-imbursements to primary care physicians become more comparable to specialist physicians, it will be difficult to attract enough qualified providers into primary care to care for the increasingly complex medical problems faced by our growing elderly population.

**Submitter :** **Dr. Frank Farmer** **Date: 07/12/2006**

**Organization :** **Dr. Frank Farmer**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

If we are to continue to have any primary care physicians it is imperative that we address these issues now.

**Submitter :** **Dr. Saba Sheikh** **Date: 07/12/2006**

**Organization :** **Dr. Saba Sheikh**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I am writing to express my support for the propsed increase in the RVU value for E&M services. This increase will enable me to keep my practice open to provide care to my patient population.
I have been in practice as an Internist/Primary Care Physician for the last 13 years. In this time period I have seen the complexity of my patient visits increase manyfold. I am struggling to provide the best care I can while my reimbursements shrink and my overheads continue to rise.
In Diabetes Care we have seen more stringent recommendations, push for stricter control and thankfully, an explosion in the pharmaceuticals available to make all of that possible. All of this takes time and tremendous effort on my part and the patient's part.
In Hypertension and Hyperlipidemia care, we have more stringent control guidelines. Managing multiple medications to deliver the recommended results while keeping patients safe requires complex decision making, effort and time.
As the population ages, the older and elderly patients increase in number in an Internist's practice. Majority of these patients are Medicare benificiaries. Providing good qualty care to these patients takes enormous amounts of physician and staff time. Multiple medical problems coupled with a large number of medications increase the work load in the office and the hospital manyfold.
As an Internist, I am front line in managing these patients. I am the one who coordinates the medications written by many other specialists. I am the physician who coordinates home care and I am the one the patients call for any and all problems. Majority of my services are E&M services. The only way I can continue to practice my specialty is by a reasonable payment structure. This E&M RVU increase will go a long way to keep me in practice and help me to continue what I like to do best. Provide care to patients to the best of my ability.
I anticipate some resistance to this proposed increase from various sources who will be biased due to their personal place in the health care field. I urge you to keep the unbiased source of the recommendations in mind and disregard the biased opponents.
The ACP has expressed major concern about the impending collapse of primary care, as you are probably aware. This recommended increase would do much to avoid that collapse.

Thank you for this chance to express my opinion.
Saba Sheikh M.D

**CMS-1512-PN-371** **Five Year Review of Work Relative Value Units Under the Physician Fee Schedule**

**Submitter :** Dr. Howard Axe **Date & Time:** 07/12/2006

**Organization :** Medical Care Group

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Please finalize the recommended work RVU increases for evaluation and management services.
As a practicing internist, I can testify first-hand how the work related to caring for hospitalized patients and outpatients has increased during the past 10 years. First, patients are living longer and have more chronic illnesses. This, combined with newer treatments and medications, including treatments for disorders which didn't have effective treatments in the past, has increased the primary care physician's workload. Patients are taking more medications, and the possibility of drug interactions must be monitored. More preventative services need to be discussed. Newer treatment options for acute and chronic illnesses need to be reviewed. All of this increases the work and cost of providing care. Please heed the pleas of those of us doctors on the front lines who want to continue to provide care, but are feeling enormous pressures to keep our businesses running, for the health of our patients and our nation.

**Submitter :** Dr. **Date:** 07/12/2006

**Organization :** Dr.

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I would like to indicate my support, as a primary care provider in internal medicine and pediatrics, for the recommend work RVU increases for evaluation and management services. Since I have been in practice, the complexity of outpatient primary care has increased significantly, requiring more time in each outpatient visit in order to sufficiently care for patients. However, this has been difficult to manage in my practice since this does not allow me to see as many patients. The work RVU increases will help to adjust for this change substantially. This is important for patient care because it will allow pts continued accesss to primary care services, which are essential to keeping patients well enough to prevent hospitalization.

**Submitter :** **Date: 07/12/2006**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

As an internist, I fully support increasing the RVU's for E/M services. The work of taking a careful history and making complex medical decisions has been woefully undercompensated as compared to procedural services, and the move to correct this is long overdue. As our patient population ages, the complexity of their chronic medical illnesses has continued to increase, and the need for a strong population of primary care providers has only grown. Finalizing the proposed corrections would be a step in the right direction towards ensuring that we have an adequate supply of PCP's and the sufficient care of people's chronic medical needs.

**Submitter :** **Dr. Claudia Leonard** **Date: 07/12/2006**

**Organization :** **Providence St. Vincent Medical Center**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I am writing to strongly support finalization of the recommended work RVU increases for evaluation and management services. The complexity of caring for patients with multiple chronic medical illnesses has greatly increased and requires alot of non face-to face time ( i.e. non-reimbursable) to coordinate. As a faculty member for an internal medicine residency, I am continually saddened to see young doctors' reluctance to go into primary care. Access is already a great problem for Medicare patients in our area, and young doctors are missing the opportunity to do very rewarding work as they simply cannot afford the low salaries that primary care physicians typically make when coupled with their school debt. I hope you reject any comments that would lower the overall improvements in work RVUs for E/M services, and I would even like to see more changes that help to equalize the great reimbursment disparities between primary care and proceedural based specialities. There should be appropriate compensation for caring for a total person, helping prevent disease, managing complicated illnesses, coordinating care for the infirm who have difficulty making it to appointments, assisting with end of life decision making and all the other things that primary care physicans do to promote good health rather then just paying doctors to 'do' things to people. Thank you for your consideration.
Sincerely,
Claudia Leonard, MD

**Submitter :** **Date: 07/12/2006**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am an infectious disease specialist who takes care of many Medicare patients here in Pennsylvania. I urge CMS to finalize the recommended work RVU increases for evaluation and management services. In my practice, the complexity of taking care of patients has increased dramatically during the past ten years. The proposed changes will help assure continued access to primary care services. I request CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services

**Submitter :** **Dr. Eileen Baade** **Date: 07/12/2006**

**Organization :** **Dr. Eileen Baade**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I would encourage your support of the initiative to increase the RVU assigned to E&M services to more accurately assess the work involved. I am concerned that the undervalued current assessment will further deter phyicians from entering primary care. My patient population includes a large number of Medicare beneficiaries and I feel we need to do our best to serve their needs in the best way possible.

**Submitter :** Dr. Adam Tsai **Date:** 07/12/2006

**Organization :** University of Pennsylvania

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I hope CMS will implement the recommended work RVU increases for evaluation and management services. The proposed changes will help assure continued access to primary care services, as less and less medical school graduates are choosing generalist fields. Our health care system needs more primary care physicians to ensure high quality care, and improving financial incentives will help ensure that more graduate choose this path. Thank you. -Adam Gilden Tsai, MD, Philadephia, PA

**Submitter :** **Dr. Richard allman** **Date: 07/12/2006**

**Organization :** **albert einstein medical center**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I am an internist who takes care of many Medicare patients here in Pennsylvania.
. I urge CMS to finalize the recommended work RVU increases for evaluation and management services.
. In my practice, the complexity of taking care of patients has increased dramatically during the past ten years.
. The proposed changes will help assure continued access to primary care services.
. I request CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.

**Submitter :** **Dr. Charles Gordon** **Date: 07/12/2006**

**Organization :** **Medical Associates of the Lehigh Valley**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a practicing internist/ geriatrician with 30 years experience. Although I had hoped to practice 10 more years, with rising expences and no significant raise in Medicare rates x 10 years, I plan to leave clinical practice on January 1, 2007. Many of my 40 partners are already closed to Medicare. I take care of sick elderly pateints average age 77-85 with multiple diseases and an average of 5- 7 medications. For my effort I am reimbursed only a small percentage of what the radilogist gets for reading an MRI or ct scan in 2 minutes, yet I make life/ death decisions and actually talk to my patients and their family. I see my pateints daily in the hospital and provide continuity of care + caring. I do not punch a time clock like many of the new breed of internists/ hospitalists. Although I love my patients and we are respectful and devoted to each other, I can no longer practice with falling pay, rising expenses, increased liability + insurance and formulary requirements causing my costs to rise exponentially. Rather than reduce quality of ocare, I will leave the clnical arena and let the chips fall where they may. Perhaps the PA's and nurse practitioners can try to care for all the complex patients I have attracted in my years of practice.
I can no longer afford to stay in private practice and without immedicate and significant relief that must be ongoing to make up for 10 years of cuts, I will leave clinical practice for medical legal consultations which I now do nights and weekends to subsidize my day job.

Who will take care of you as you age?

**Submitter :** Dr. Gregory Harper **Date:** 07/12/2006

**Organization :** Hematology Oncology Assoc, Lehigh Valley Hospital

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

Medical oncologists are being called to respond to Institute of Medicine recomendations for improving patient safety, outcomes, and satisfaction in the continuity of cancer care. In so doing, we find ourselves increasingly, and appropriately in a decision sharing relationship with patients and their families. This decision sharing requires careful and detailed outlining of the complexities of diagnosis, extent of disease, prognosis, treatment options, risks and benefits, and includes increased attention to achieving successful palliation of multiple symptoms. Coordination of care with other specialty physicians and disciplines, not the least of which is collaboration with oncology and home care nurses to optimize the patient experience across the continuum of care requires an increasing amount of time to accomplish successfully. The levels of care required to achieve expected outcomes simply cannot be delivered in a routine 15-20 minute visit, and increasingly requires not only direct physician time but also the ongoing supervision of care delivery. I strongly support recommendations to increase E&M reimbursement to reflect the complexity of services delivered to our patients and their families. Thank you.

**Submitter :** **Date: 07/12/2006**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I am an internist who takes care of many Medicare patients here in Pennsylvania. I urge CMS to finalize the recommended work RVU increases for evaluation and management services. In my practice, the complexity of taking care of patients has increased dramatically during the past ten years. I am trying to provide the best possible care for my patients and as an internist have very few procedures which typically are reimbursed at much higher rates than complex cognitive skills and time with patients. The proposed changes will help assure continued access to primary care services. I request CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.

**Submitter :** Dr. douglas atlas **Date:** 07/12/2006

**Organization :** Dr. douglas atlas

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

I am a practicing internist in pennsylvania. I firmly belive that the current payment system is flawed, and I encourage CMS to approve the proposed revision to the E&M system. If such a change does not occur, I (and many physicians like me) may not be able to continue to provide care to medicare patients.

**Submitter :** Dr. Stephen Montamat **Date:** 07/12/2006

**Organization :** Dr. Stephen Montamat

**Category :** Physician

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

We are facing a critical juncture in health care concerning the viability of physicians performing primary care for the citizens of our country. There has been a relative erosion in the financial reimbursement for primary care over the past decade, and the complexity of typical medical patients has risen significantly over that same time period. These realities have driven away prospective doctors from entering general Internal Medicine and Family Practice careers. Studies have shown that the quality and cost of care are correlated to the availability of primary care physicians, such that more primary care physicians results in better care at lower costs. Therefore, the proposed increases in RVU values for evaluation & management (E&M) services are sorely needed to avert a true crisis in our health care system.

**Submitter :** **Date: 07/12/2006**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a practicing geriatrician and take care of many Medicare patients here in Pennsylvania.
I urge CMS to finalize the recommended work RVU increases for evaluation and management services since in my practice, the complexity of taking care of patients has increased dramatically. The reimbursement for the time that I spend taking care of the most vulnerable of the population is not sufficient enough to allow me to continue to adequately care for this population.I believe, however, that the proposed changes will help assure continued access to primary care services.
I request CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.

**Submitter :** Dr. Richard Neubauer **Date:** 07/12/2006

**Organization :** Richard Neubauer MD, FACP

**Category :** Individual

**Issue Areas/Comments**

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

Discussion of Comments- Evaluation and Management Services

Primary care in this country is near collapse. I urge CMS to finalize the recommended work RVU increases for E&M services. I know from my own practice that this will make a real and substantial impact in caring for my patients and will help me to continue my efforts to provide access to care for my patients. I urge CMS to reject the inevitable comments from subspecialists and specifically procedurists who may resent re-distributioin of funds and may urge that there be a lowering of the overall improvements in work RVUs for E/M services.

**Submitter :** **Date: 07/12/2006**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

7 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.

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

7 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.

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

**Submitter :** **Dr. Ronald Barrios** **Date: 07/12/2006**

**Organization :** **Dr. Ronald Barrios**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am an internist who takes care of many Medicare patients here in Pennsylvania. I urge CMS to finalize the recommended work RVU increases for evaluation and management services. In my practice, the complexity of taking care of patients has increased dramatically during the past ten years. The proposed changes will help assure continued access to primary care services I request CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services. These changes would be long overdue to balance the reimbursement rates for primary care physicians.

**Submitter :** Dr. Stephen Dietrich **Date:** 07/12/2006

**Organization :** Dr. Stephen Dietrich

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

7 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.

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7 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.

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

**Submitter :** **Dr. Joseph Billig** **Date: 07/12/2006**

**Organization :** **Vail Valley Medical Center**

**Category :** **Physician**

**Issue Areas/Comments**

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

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

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

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

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

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

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

**Submitter :** **Dr. Tim VadeBoncouer** **Date: 07/12/2006**

**Organization :** **Anesthesiology, UIC, Chicago, IL**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Regarding the Five Year Review as it pertains to ANESTHESIOLOGY:

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

7 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.

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

7 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.

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

**Submitter :** **Dr. Ali Jaffer** **Date: 07/12/2006**

**Organization :** **Dr. Ali Jaffer**

**Category :** **Physician**

**Issue Areas/Comments**

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

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

Dear Sir or Madam:

I am an anesthesiologist and am disturbed by the planned cuts to my profession - anesthesiology. Anesthesiologist services are far undervalued.

7 As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties.
7 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.
7 CMS should gather new overhead expense data to replace the decade-old data currently being used.
7 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.
7 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.

Thank you for your time.

Sincerely,

Ali Jaffer, MD

**Submitter :** **Dr. Kimberly King** **Date: 07/12/2006**

**Organization :** **Old Pueblo Anesthesia**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Dear Sirs/Madames:

I write to you on behalf of a concerned Anesthesiologist. In an environment where we alrady have a paucity of Physicians able to provide care to an ever-aging population with more complex medical issues, if frightens me that as it stands payment to us for taking care of such individuals is going to be further cut.

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.

I believe that CMS should gather new overhead expense data to replace the decade-old data currently being used. To support such efforts the ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.

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 medieine.

Please consider this prior to further burdening us when we choose to take eare of these often very complex patients. I am part of a group who still chooses to care for the aging population, however, may people have been leaving groups such as mine because they don't believe taking on such great liability for such little payment is worth the risk. If payments are cut further, I believe this trend will grow, thus, leaving a smaller and smaller pool of physicians to care for a growing population. The shortage of caretakers will only worsen in such a situation.

Sincerely Concerned,
Kimberly M King, MD

**Submitter :** Dr. Kyle Jones **Date:** 07/12/2006

**Organization :** uab medical

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

**Submitter :** Dr. Thomas Gillock **Date:** 07/12/2006

**Organization :** American Society of Anesthesiologists

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Lowering payments to anestheisoligsts will limit the elderlies ability of access care. Your payments are already so low; and, further reductions will just make care for the elderly harder to obtain.

**Submitter :** **Dr. William Moore** **Date: 07/12/2006**

**Organization :** **Dr. William Moore**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

To whom it may concern,

The proposed cuts of 10% in Medicare funding for Anesthesiologists are unacceptable. The result of such drastic cuts will be fewer anesthesiologists taking care of seniors resulting in substandard care from lower level providers. Solving the problem of Medicare funding should not be done on the backs of hardworking physicians.

**Submitter :** **Dr. manuel arce** **Date: 07/12/2006**

**Organization :** **private anesthesiologist**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

I am a new anesthesiologist that just entered the work force and I have seen with my limited experience ,that the cost of providing quality has increased. To have better Machines, monitors, the newest drugs on the market,and the best trained individuals all of this cost money. By decreasing reimbursements by close to 10 % in the next ten years, it would be underestimating and devaluing the job of the anesthesiologist. Better research should be conducted before making such haste decisions, that could have such deep impact. I belive that
cutting the budget by such percentage would impair the quality of care provided. Thank you for reading this statement.

**Submitter :** **Dr. Judith Hutchinson** **Date: 07/12/2006**

**Organization :** **Dr. Judith Hutchinson**

**Category :** **Physician**

**Issue Areas/Comments**

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

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

If you've ever needed anesthesia care, you'd know we're not 'miscellaneous'. We keep people alive.

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

7 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.

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

7 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.

7 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.

If push comes to shove, I WILL stop accepting Medicare.

Judith T. Hutchinson, M.D.
Board Certified Anesthesiologist