Submitter : Ms. Linda Rosenberg **Date:** 10/06/2006

Organization : National Council for Cmty Behavioral Healthcare

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P-315-Attach-1.PDF

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

LINDA ROSENBERG, MSW, CSW ELIZABETH HINK, MBA

October 6, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1506-P

Dear Dr. McClellan:

These comments on the Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates are submitted on behalf of the National Council for Community Behavioral Healthcare. The National Council is a not-for-profit association of 1,300 behavioral healthcare organizations that provide treatment and rehabilitation for mental illnesses and addictions disorders to nearly six million adults, children and families in communities across the country. Medicare's Partial Hospitalization Program (PHP) is critically important to the adults and children our members treat. We urge you to correct or clarify a number of issues to ensure that individuals with psychiatric disabilities retain access to this important Medicare-funded source of mental health services and supports.

The Centers for Medicare and Medicaid Services (CMS) is proposing a 15 percent reduction in reimbursement rates for hospitals, community mental health centers (CMHCs) and ambulatory mental health care providers participating in the PHP program for calendar year (CY) 2007 effective January 1, 2007. This proposed PHP daily rate is on top of 2 percent reduction in CY 2005 and a staggering 12 percent reduction in CY 2006. We have received widespread reports from CMHCs throughout the country that the new rates are so low that it would be impossible to actually offer PHP services.

A result of this kind is clearly contrary to congressional intent and would represent a tragedy to many individuals with serious mental illnesses currently served by PHP programs. Partial hospitalization is usually prescribed for individuals who have just been discharged from public or private inpatient psychiatric hospitals. Typically, physicians make referrals to

PHPs when they have been a medical determination that a patient needs intensive support and supervision to ensure an appropriate transition back to life in the community.

Additionally, we have concerns with the methodology used to calculate the proposed 15 percent rate cut. CMS describes the data it uses as representative of the mean of actual operating costs; however, for CY 2007, CMS is proposing costs based on 2005 data that does not consider increases in operating costs or inflation for the past two years. Additionally, CMS determines cost based on cost-report data submitted and requires at least four treatments per day for PHP. Using the current recommended rate of group psychotherapy, the lowest cost applicable treatment procedure at $66.40 per group, this translates to $265.60 per patient per day. The current bundled per diem rate proposal for PHP is $208.27 per patient– requiring providers to lose $57.33 per patient per day.

The National Council urges you to suspend the proposed 15 percent cut and to create a behavioral health task force to establish a more effective method of calculating rate changes and to preserve the availability of this important lower-cost benefit.

Thank you for the opportunity to submit comments on the proposed rate cut. Please feel free to call if we can offer any assistance on this issue.

Sincerely,

Linda Rosenberg, MSW, CSW
President and CEO

Submitter : **Ms. Kathleen Kowalchik** **Date: 10/06/2006**

Organization : **Danbury Hospital**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

Section IX.B. Proposed Coding- We accept the need for creation of new G- codes for hospital clinic, Emergency Department and Critical care visits. We are requesting consideration of a change in description for the proposed Clinic visit codes Gxxx1-Gxxx5. A number of other outpatient areas that are not designated as clinics, provide visit services. The descriptor 'Level X hosp clinic visit' will lead to confusion as to whether these codes are appropriate for these non- clinic outpatient settings. Examples of these services are Outpatient Infusion Centers, Outpatient Oncology Centers, Wound Care Centers and Outpatient Maternity Services. A more generic description that removes the word 'clinic' or adds 'other outpatient' would eliminate any confusion that it is acceptable to use these G-codes for non-clinic settings. 'Level X outpaticnt hosp visit' or 'Level X hosp clinic or other outpatient visit'. A changc in the guideline description as well from Clinic Visit Guidelines to Clinic or other outpatient Visit Guidelines is recommended.

D. Proposed Treatment of Guidelines - We agree the 5 levels of service are appropriate for both Emergency Department and clinic/other outpatient visits. We also agree there are instances where the valuing seems inconsistent.
Specifically: Clinic intervention Level 1, specimen collection other than venipuncture & We recommend a limited number, 1-2 collections as a Level 1; with 3 or more collections being identified as a Level 3 intervention. We would recommend adding other resource intensive services as contributory factors, for example coordinating with other third parties such as home care SNFs, referring physicians regarding patient status and or change in orders.
There do not appear to be enough Level 1 asterisk interventions to meet the criteria for Level 2, nor enough Level 3 interventions to meet the criteria for Level 3, or 4 on. Geriatric patients often require additional resource assistance such as wheelchair, clothing, restroom assistance, chair weights, memory testing. These could be added to Level 1.
Reviewing medications with the patient, calling a Pharmacy ordering new or changing prescriptions are all common clinic serviccs that can be contributory factors. Interpretive services (sign language, foreign language) are another recommended contributory factor.

Thc collection of blood from a venous catheter, often repeatedly for lab protocols is suggested equal to a Level 3 intervention. Obtaining authorizations, pre-ccrtifications is resource intensive. In particular obtaining authorization for a series of treatments such as behavioral health or radiation oncology can frequently take an hour or more of staff timc. While Medicare may not require prior authorization, hospitals will be using these guidelines for all payers. Referring, scheduling and providing instructions for procedures including MRI, MRA and PET are resource intensive that would qualify for Level 3 interventions.
Thank you for your consideration,

Kathleen Kowalchik RN, CPC, CPC-H, CCS-P, CCS
Revenue Cycle Manager, Corporate Compliance
Danbury Hospital

Submitter : Dr. Ernst Valfer **Date:** 10/06/2006

Organization : LaCheim Behavioral Health Services

Category : Other Health Care Provider

Issue Areas/Comments

Policy and Payment Recommendations

Policy and Payment Recommendations

LA CHEIM BEHAVIORAL HEALTH SERVICES
5263 Claremont Avenue
Oakland, CA 94618-1032
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October 6. 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Mail Stop: C4-26-05
7500 Security Blvd.
Baltimore, Md. 21244-1850

To Whom It May Concern:

Re: PPS-CMS-1506-P; CY 2007 Proposed Daily Rate for APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 Outpatient psychiatric services

La Cheim Behavioral Health Services operates two freestanding Community Mental Health Centers in Oakland and Berkeley, CA. We serve approximately 300 patients on an annual basis. We provide intensive psychiatric programs, including partial hospitalization services that are greatly needed by the severe and persistently mentally ill and the elderly in our community.

All of our patients have had prior in-patient hospitalizations with severe Axis I disorders and are in danger of rehospitalization if not treated in a partial hospitalization program.

We are requesting that CMS cease from going forward with the proposed CY 2007 15% rate cut for Partial Hospitalization (PHP) and psychiatric Outpatient Services. Coupled with last year s 12.5% reduction for PHP, the proposed rate will make it impossible to cover the costs needed to provide an intensive program. We do not see how we could continue to operate after this proposed rate cut since we have not other programs, as some hospitals do, that could subsidize these services.

We strongly support the position of the Association of Ambulatory Behavioral Healthcare regarding their proposed considerations, as the response from the organization goes into specific detail concerning the long reaching effects the rate cut will have on the patients who are in need of outpatient psychiatric services.

While your reimbursement formula, however seriously flawed, at least provides an area adjustment for labor costs, the costs for rent, utilities, insurance, fuel, etc. are immensely larger in this metropolitan area than almost anywhere else in our country and are not area adjusted.

Our less expensive outpatient programs need to be supported by reasonable reimbursement rates that adequately cover the costs of providing the services.

We are asking CMS to allow time and resources to develop a reasonable payment methodology by working with provider and community organizations who would welcome the opportunity to work with CMS to develop a payment rate that is fair, consistent and predictable.

Thank you, for the opportunity to respond to this most critical issue.

Respectfully,

Ernst S. Valfer, Ph.D., ABPP, CGP
Director

Submitter : Dr. Miguel Nunez **Date: 10/06/2006**

Organization : Green Cross, Inc.

Category : Physician

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

There are several points to be made on the suggestion the proposed rule to decrease reimbursement for partial hospitalization by 15%.

Use of the CCR from one year to estimate costs of another year is inherently flawed in the case of CMHCs. I have commented on this in previous years.

When charges are decreased and a CCR from a period when charges were higher is applied you get the aberration that is reported showing a low cost for CMHCs. The idea that you can take a CCR from one year and apply it to another year makes no sense for the non-hospital based outpatient providers such as CMHCs.

CMS should have pretty good data on the cost of PHP in the CMHC setting from settled cost reports. It is clear from cost reports for FY 2004 and 2005 that CMHC costs per day of PHP run in excess of $300 per day.

The rate of inflation for outpatient health services has been variously reported in the last few years to range between 8-11% per year. It is well established that overall health care costs rise above the general inflation rate in the economy. It is reasonable and more accurate to estimate the costs of a day of PHP to have increased by 10%, i.e., in the neighborhood of $341 per day. Using this methodology you eliminate problems of changing charges from year to year.

Other issues have come up with CMHCs of late that have also driven up costs. The rapid rise in real estate values in many of the metropolitan areas have increased rents for CMHCs. In many metropolitan areas new CMHCs have come into the market and are providing PHP services this has reduced the average daily census in many PHP programs while fixed costs have remained steady or increased.

There is another deeply worrisome point to be made with regards to the proposed rule. On page 49684 of the Federal Register (Vol. 71, No. 163) we find the following statements:

"The lowest volume hospitals experience the largest decrease of 7.1 percent, largely as a result of decreases in payment for partial hospitalization and psychotherapy services."

"We project that hospitals for which a DSH percentage is not available, including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals would experience decreases in payments of 8.9 percent, and for the urban subset, 9.2 percent, largely as a result of proposed changes to partial hospitalization and psychotherapy payments."

On page 49685 of the Federal Register (Vol. 71, No. 163) we find the following statement:

"We estimate that low-volume urban hospitals would experience a deerease in total payments of 3.2 percent between CY 2006 and CY 2007, largely as a result of changes to payment for partial hospitalization, psychotherapy, and radiation therapy services."

On page 49686 of the Federal Register (Vol. 71, No. 163) we find the following statement:

"We project that low-volume rural hospitals would experience the lowest increase in overall payment of 0.8 percent (due largely to changes in payment for partial hospitalization, psychotherapy, and radiation services)."

These statements suggest a systematic attempt to reduce health care costs off the backs of one of our most vulnerable and least vocal segments of our populace, the mentally ill. It would be cruel to achieve budget neutrality simply by railroading this group that is in such need of care. The mentally ill, who receive good health care, can be very productive members of society - they should not be marginalized.

No mention is made of the impact on CMHCs, which are the front line in rendering the mentally ill health care services so they can stay out of the hospital and remain integrated as valuable members of our society.

I can tell you from my 12 years of experience as a C.E.O of a CMHC that costs per day of PHP hover around $325-$375. Reimbursement should increase by 15% for PHP in the CMHC setting.

CMS-1506-P-318-Attach-1.DOC

Comments on: **CMS-1506-P - Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Partial Hospitalization

There are several points to be made on the suggestion the proposed rule to decrease reimbursement for partial hospitalization by 15%.

Use of the CCR from one year to estimate costs of another year is inherently flawed in the case of CMHCs.

When charges are decreased and a CCR from a period when charges were higher is applied you get the aberration that is reported showing a low "cost" for CMHCs. I have stated this problem before in previous comment periods. The idea that you can take a CCR from one year and apply it to another year makes no sense for the non-hospital based outpatient providers such as CMHCs.

CMS should have pretty good data on the cost of PHP in the CMHC setting from settled cost reports. It is clear from cost reports for FY 2004 and 2005 that CMHC costs per day of PHP run in excess of $300 per day. Using this methodology you eliminate problems of changing charges from year to year.

The rate of inflation for outpatient health services has been variously reported in the last few years to range between 8-11% per year. It is well established that overall health care costs rise above the general inflation rate in the economy. It is reasonable and more accurate to estimate the costs of a day of PHP to have increased by 10%, i.e., in the neighborhood of $341 per day.

Other issues have come up with CMHCs of late that have also driven up costs. The rapid rise in real estate values in many of the metropolitan areas have increased rents for CMHCs. In many metropolitan areas new CMHCs have come into the market and are providing PHP services this has reduced the average daily census in many PHP programs while fixed costs have remained steady or increased. It would be a terrible mistake at this time to once gain cut reimbursement for this much needed program.

There is another depply worrisome point to be made with regards to the proposed rule. On page 49684 of the Federal Register (Vol. 71, No. 163) we find the following statements:

> The lowest volume hospitals experience the largest decrease of 7.1 percent, largely as a result of decreases in payment for partial hospitalization and psychotherapy services.
>
> We project that hospitals for which a DSH percentage is not available, including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals would

> experience decreases in payments of 8.9 percent, and for the urban subset, 9.2 percent, largely as a result of proposed changes to partial hospitalization and psychotherapy payments.

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These statements suggest a systematic attempt to reduce health care costs on the backs of the one of our most vulnerable and least vocal segments of our populace, the mentally ill. It would be cruel to achieve budget neutrality simply by railroading this group that is in such need of care. The mentally ill, who receive good health care, can be very productive members of society - they should not be marginalized.

No mention is made of the impact on CMHCs, which are the front line in rendering the mentally ill health care services so they can stay out of the hospital and remain integrated as valuable members of our society.

In fairness, reimbursement for PHP services in the outpatient setting of CMHCs should increase. I can tell you from my 12 years of experience as a Chief Executive Officer of a CMHC that cost run in the neighborhood of $325-$375 per day and not less. In fact each year it becomes more difficult to provide this level of care at those rates. I appeal to you to rethink this proposed rule.

Submitter : Mr. Gary Delhougne **Date:** 10/06/2006

Organization : Tyco Healthcare Valleylab

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P-319-Attach-1.DOC

tyco / Healthcare / Valleylab

October 6, 2006

Submitted via www.cms.hhs.gov/eRulemaking

Mark B. McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1506-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1506-P
Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; Proposed Rule

Dear Dr. McClellan:

Valleylab, a division of Tyco Healthcare Group L P, is submitting these comments in response to the August 23, 2006 proposed rule: Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates. Valleylab is the world leader in the innovation and manufacture of advanced energy based medical systems including devices for the radiofrequency ablation of lesions and tumors. Valleylab is submitting comments specific to **"Other New Technology Services."**

Efforts to Address Radiofrequency Ablation (RFA) Reimbursement
Over the past year and a half Valleylab has actively engaged CMS's assistance in remedying various RFA reimbursement issues:

- In the prior year's rulemaking period Valleylab commented and CMS agreed to reassign two laparoscopic RFA procedures (CPTs 47370 and 50542) to a resource appropriate APC based on the two times rule;
- Valleylab worked with Pat Brooks of the Division of Acute Care to secure twelve ablation specific ICD-9-CM Procedure codes effective October 1, 2006;
- Valleylab submitted to the Division of Outpatient Care an application for an additional device category code to help hospitals bill for the RF device appropriately a nd thereby p rovide more accurate paid claims data to CMS for future rate-setting purposes; and

- In the current year's proposed rule CMS is proposing to place three integral imaging guidance codes (CPTs 76362, 73294, and 76940) onto the bypass list, an action that Valleylab supported in our comments to the prior year's proposed rule.

In light of these efforts we respectfully submit the following comment to CMS:

Comment

Valleylab respectfully requests that CMS reassign CPT 20982 (Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance) from New Technology APC 1557 to clinical APC 0051, not APC 0050 as proposed by CMS. Valleylab believes APC 0051 is a more resource appropriate APC for the following reasons:

- **CPT 20982's median cost is 18.5 percent higher than APC 0050's median cost;**
- **CPT 20982's median cost is higher than the median cost of 25 percent of APC 0051 HCPCS;**
- **Physician Fee Schedule CPEP data shows that the cost of supplies and personnel to perform CPT 20982 is $2,249;**
- **The cost of most RFA electrodes are greater than APC 0050's proposed 2007 payment rate of $1,542; and**
- **CPT 20982's payment is inclusive of computed tomographic guidance whereas all other device based ablation procedures receive a separate payment for imaging guidance.**

What is Radiofrequency Ablation?

Radiofrequency ablation involves the percutaneous, laparoscopic, or intraoperative insertion of a radiofrequency energy emitting electrode into a lesion or tumor with the assistance of imaging guidance. Radiofrequency (RF) energy is used to rapidly heat and destroy diseased tissue, leaving the surrounding healthy tissue unharmed. Protein denaturation and coagulation are the ultimate cause of cell death. This is an important new tool for clinicians to treat various forms of cancer and has been shown to significantly improve net health outcomes in patients who are not appropriate candidates for conventional surgery.

Median Cost Analysis

A review of the two years of available paid claims data for CPT 20982 demonstrates that the median cost of the procedure is rising. The numbers of "single" frequency procedures increased from 2004 to 2005 while the True Median Cost for the procedure increased by 20 percent or $319. When CPT 20982's median cost is compared against CMS's proposed APC 0050 the procedure's median cost is $350 or 23 percent higher.

CY 2005 Paid Claims Data used to set CY 2007 Rates							
CPT/ HCPCS	"Single" Frequency	"Total Frequency"	Minimum Cost	Maximum Cost	Mean Cost	**"True" Median Cost**	CV
20982	27	59	243.35	4,954.76	2,351.18	**1,897.59**	60.027

CY 2004 Paid Claims Data used to set CY 2006 Rates								
CPT/ HCPCS	APC	Payment	"Single" Frequency	Minimum Cost	Maximum Cost	Mean Cost	**"True" Median Cost**	CV
20982	1557	1850.00	17	285.47	3499.49	1823.67	**1578.34**	47.423

Valleylab believes that a more appropriate clinical home for CPT 20982 is APC 0051. CPT 20982's median cost is higher than the median cost of 25 percent of APC 0051's procedures.

Physician Fee Schedule CPEP Data

CMS's CPEP data regarding the supply, clinical time and capital expense for performing procedures should be used by CMS to recognize the true cost of the procedure. The following is a supply cost list for the procedure.

CPT 20982: BONE TUMOR ABLATION, RF, PERC, W/ CT GUIDANCE CPEP/RUC SUPPLY COST REPORT

HCPCS	Source	Description	UNIT_05	QTY_05	**Price**	**QTY_NF**	**Cost-NF**
20982	RUC	probe, radiofrequency, 3 array (StarBurstSDE)	item	1	**1995**	**1**	**1995**
20982	RUC	cautery, patient ground pad w-cord	item	1	**3.07**	**1**	**3.07**
20982	RUC	scalpel with blade, surgical (#10-20)	item	1	**0.694**	**1**	**0.694**
20982	RUC	drape, sterile, fenestrated 16in x 29in	item	1	**0.557**	**1**	**0.557**
20982	RUC	drape, sterile, three-quarter sheet	item	1	**3.83**	**1**	**3.83**
20982	RUC	drape-towel, sterile 18in x 26in	item	1	**0.282**	**4**	**1.128**
20982	RUC	gloves, sterile	pair	1	**0.84**	**2**	**1.68**
20982	RUC	gown, surgical, sterile	item	1	**4.671**	**2**	**9.342**
20982	RUC	mask, surgical, with face shield	item	1	**1.199**	**3**	**3.597**
20982	RUC	shoe covers, surgical	pair	1	**0.338**	**3**	**1.014**
20982	RUC	underpad 2ft x 3ft (Chux)	item	1	**0.23**	**1**	**0.23**
20982	RUC	needle, 18-27g	item	1	**0.089**	**2**	**0.178**
20982	RUC	syringe 10-12ml	item	1	**0.184**	**1**	**0.184**
20982	RUC	syringe 20ml	item	1	**0.558**	**1**	**0.558**
20982	RUC	kit, radiofrequency introducer	kit	1	**50**	**1**	**50**
20982	RUC	pack, conscious sedation	pack	1	**17.311**	**1**	**17.311**

20982	RUC	pack, minimum multi-specialty visit	pack	1	**1.143**	**1**	**1.143**
20982	RUC	tray, biopsy procedure	tray	1	**14.65**	**1**	**14.65**
20982	RUC	tray, shave prep	tray	1	**1.812**	**1**	**1.812**
20982	RUC	cup, biopsy-specimen sterile 4oz	item	1	**0.173**	**1**	**0.173**
20982	RUC	cup-container, sterile, graduated 1000ml	item	1	**1.14**	**1**	**1.14**
20982	RUC	povidone soln (Betadine)	ml	1	**0.008**	**60**	**0.48**
20982	RUC	silver nitrate applicator	item	1	**0.07**	**1**	**0.07**
20982	RUC	tincture of benzoin, swab	item	1	**0.32**	**1**	**0.32**
20982	RUC	lidocaine 1%-2% inj (Xylocaine)	ml	1	**0.035**	**10**	**0.35**
20982	RUC	sodium chloride 0.9% irrigation (500-1000ml uou)	item	1	**2.074**	**1**	**2.074**
20982	RUC	applicator, sponge-tipped	item	1	**0.139**	**4**	**0.556**
20982	RUC	gauze, sterile 4in x 4in	item	1	**0.159**	**3**	**0.477**
20982	RUC	steri-strip (6 strip uou)	item	1	**1.116**	**1**	**1.116**
20982	RUC	tape, surgical paper 1in (Micropore)	inch	1	**0.002**	**12**	**0.024**
					TOTAL SUPPLY COST:		**$ 2,113**

While we understand that CMS does not usually take into consideration non-claims related data, a review of the recently submitted and publicly available practice expense data demonstrates that the actual cost to perform the procedure far surpasses the payment rate of APC 0050.

The costs of the supplies for the procedure are considerable. As shown above the total cost of all supplies necessary to perform the procedure is $2,113. Plainly, many supply costs are insignificant but the radiofrequency device technology cost is significant and all radiofrequency devices can only be used once.

Average Cost of Radiofrequency Ablation Electrodes

As demonstrated in the CPEP/RUC data above the average cost of a radiofrequency ablation device is high. The least expensive R F electrode is $900 but on average a hospital can expect to spend approximately $1,500, though some cost as much as $2,500. Taking into consideration the cost of one RF electrode for the procedure APC 0050's proposed payment rate is not adequate to even cover the cost of the electrode, let alone the cost of other supplies, personnel, and procedural costs. APC 0051's payment rate more appropriately covers the cost of the procedure.

Computed Tomographic Guidance

Among all radiofrequency ablation procedures (CPTs 47370, 47382, 50542, and 50592) CPT 20982 is the only code that packages into its payment reimbursement for the cost of imaging guidance.

Conclusion

In light of the cost concerns we have raised: the increase in median cost from 2004 to 2005; the CPEP/RUC data showing supply costs of $2,113; the average RF electrode cost of $1,500; and the inclusion of tomographic guidance reimbursement in the procedure payment Valleylab respectfully requests CMS to reassign CPT 20982 to APC 0051 instead of the proposed APC 0050. We appreciate the opportunity to offer our comments to CMS on its proposed 2007 Outpatient Prospective Payment System rule.

Sincerely,

-s-

Gary V. Delhougne JD, MHA
Tyco Healthcare Valleylab
675 McDonnell Blvd, 10-3-C
St. Louis, MO 63134
314-654-7238
314-654-3099 fax
Gary.Delhougne@tycohealthcare.com

Submitter : **Ms. Debra Ness** **Date: 10/06/2006**

Organization : **National Partnership for Women & Families**

Category : **Consumer Group**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

please see attached

CMS-1506-P-320-Attach-1.PDF

National Partnership
for Women & Families

October 6, 2006

Administrator McClellan
Center for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE:

Physician Fee Schedule: [CMS-1321-P] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment under Part B and

Hospital Outpatient Prospective Payment System (OPPS): [CMS-1506-P] Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates

Dear Dr. McClellan:

On behalf of the National Partnership for Women & Families, I am writing to urge CMS to reconsider proposed reductions to Medicare reimbursement for partial breast irradiation, also referred to as breast brachytherapy, for the treatment of early-stage breast cancer. For more than 35 years, the National Partnership for Women & Families has worked to promote better health care for women and families. One of our main goals is to ensure that women have access to high quality health care and a full range of treatment options.

The National Partnership is concerned that the steep Medicare reimbursement cuts to breast brachytherapy proposed in the physician fee schedule and OPPS rules will likely reduce women's access to this more patient and family-friendly treatment approach. In contrast to the required 5-6 week course of therapy with whole beam external radiation, partial breast irradiation can be completed within 5 days, allowing women to get back to their lives. Clinical studies of brachytherapy as a follow-up to lumpectomy show comparable five-year local recurrence rates to whole beam external radiation, making brachytherapy an attractive option for women who deem 5-6 weeks of radiation treatment too onerous.

We understand that the CMS proposal will result in decreased reimbursement:

- for a complete course of breast brachytherapy in a free-standing radiation oncology center or physician office by 15% in 2007 and 54% by 2010; and

1875 Connecticut Ave. NW / Suite 650 / Washington, DC 20009 / 202.986.2600 / www.nationalpartnership.org

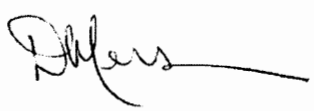
- for the procedures to implant the device into the breast for brachytherapy following lumpectomy by 23-37% in the hospital outpatient department. The newly proposed level of OPPS reimbursement will not even cover the cost of the brachytherapy device.

At the same time, more invasive procedures and therapies – mastectomies and whole beam external radiation therapy – are slated for increased reimbursement.

The National Partnership for Women & Families recognizes that breast brachytherapy is not the right course of therapy for every woman. Both the American Society of Breast Surgeons and the American Brachytherapy Society have published guidelines for selecting patients who are appropriate for this procedure.

We know that CMS shares our commitment to quality health care for women, including access to safe, effective, and patient-friendly treatments. Given the size of the proposed Medicare reimbursement cuts – and the importance of preserving the availability of this less invasive breast cancer treatment option – we ask CMS to carefully reexamine the potential impact of these reductions on Medicare beneficiaries' access to the breast brachytherapy procedure. We fear that these severe cuts are likely to drive medical decisions based on the most favorable reimbursement levels, rather than what is necessarily the best treatment option for the patient.

Sincerely,



Debra L. Ness
President

Cc: Leslie Norwalk, Deputy Administrator, CMS
Herb Kuhn, Director, Center for Medicare Management, CMS
Kathleen Harrington, Director of External Affairs, CMS

Submitter : Cathy Meeter **Date:** 10/07/2006

Organization : Sutter Health

Category : Hospital

Issue Areas/Comments

OPPS Impact

OPPS Impact

Packaged Services: Page 49535 of the FR states that 'we note that providers should bill a low level visit code in such circumstances only if the hospital provides a significant, separately identifiable low level visit in association with a packaged service.' This contradicts CMS' general policy that if a visit meets the definition of an encounter at 42 CFR 210.2 & the services are medically necessary, but the CPT code representing the service is SI 'N', it is okay to bill a low level visit code like 99211. This statement in the FR also contradicts the statement in Transmittal A-02-129 regarding billing 99211 when CPT 97602 (status indicator of 'N') was the only service reported. A hospital should not have to provide a medically necessary service for free d/t costs incurred with registration, housekeeping, staff that provides the care and indirect costs. A classic example of this is a dressing change either for a wound or for a PICC line evaluation and dressing change. There are no codes to decribe these services yet the physician can order the paient to the hospital to have these services done and the cost can only be recouped in a charge associated with an E & M code. Sutter Health respectifully requests that this practice continue to be allowed, i.e. for a hospital facility to be able to bill an E & M code for those services that have a SI of 'N'. Clarification ought to be provided to hospitals if the two codes should be submitted together or whether just the E & M code should be submitted in lieu of the packaged code.

OPPS: Drug Administration

OPPS: Drug Administration

OPPS: Drug Administration: page 49600 of the FR states that "CMS is proposing to continue the CY 2006 OPPS drug administration coding structure which combines CPT codes with several C codes.....While we are not proposing to transition to the full set of CPT codes in CY 2007, we retain this as an option for the future." Sutter Health strongly recommends that CMS adopt all of the CPT codes and eliminate the C codes for drug administration. The Critical Access Hospitals adopted the CPT codes last year and there is absolutley no reason to not have OPPS hospitals adopt them this year. OPPS hospitals like Sutter Health facilities created the descriptions for drug administration services predicated on the CPT description so the concepts have been in use for a year. There is no need to maintain separate codes and as a matter of fact this is a burden to maintain different code sets for a single payer, i.e. Medicare. Also, not all commercial payers accept the C codes. Sutter Health respectfully requests that all the C codes be eliminated and CMS adopt the CPT codes in their entirety for drug administration services.

Policy and Payment Recommendations

Policy and Payment Recommendations

OPPS:Non-Pass-Through Drugs, Biologicals and Radiopharmaceuticals: page 49595 of the FR states ".....There are three HCPCS codes for which we not able to determine payment rates based on the ASP methodology. The HCPCS codes are 90393 (Vaccina ig, IM), 90693 (Typhoid vaccine, akd, sc) and A9567 (Technitium TC-99m acrosol). Because we are unable to to estimate the per administration cost of these items, we are proposing to package them in CY 2007." Page 49594 of the FR states that if the ASP is not available then CMS would use WAC and if no WAC, then AWP. I am unclear as to why the WAC or AWP is not used to estimate the cost to to ascertain if separate payment for these drugs should be made in 2007. Sutter Health respectfully requests that the alternate data sources be used to make a final determination if these drugs should be separately payable in 2007.

Visits

Visits

Visits: pages 49604 - 49619 of the FR address CMS' proposal of establishing new codes for ED and clinic visits. Sutter Health strongly recommends that CMS wait to adopt new codes until criteria to assign the new codes is ready to be distributed along with the codes. We are unclear why CMS feels the need to move ahead with these codes at this time and not wait until the associated criteria has been finalized to distribute along with new codes.

We also would strongly urge CMS to work with the AMA to develop CPT codes specifically for hospitals for clinic and ED visits so that we will not have to adopt new HCPCS codes for just the Medicare beneficiary. We cannot stress to you the burden that is placed on hospitals when they have to maintain different code sets for different payers.

In working with the AMA, we would ask that in lieu of critical care codes, a 6th ED level be created. CMS has previously instructed hospitals to create objective criteria to assign an appropriate level for care rendered to the patient in the ED or in a clinic. Sutter Health uses a point system that reflects care provided to the patient that is not otherwise billable. When points reach a certain level, that patient is determined to be at a critical care level which we consider the highest level of care provided reflecting the hospital resources = 6th level of care. We would suggest eliminating the critical care verbiage and assigning a code for a 6th level of care reflecting the hospital resources.

Sutter Health would also like to address the comments made by CMS that any critical care provided at less than the first 30 minutes should be billed at a lower level of care. We strongly disagree. Our prices have been set to reflect the level of care provided to the patient and reducing the level of care would not reflect our actual costs as well as our method of calculation to assign the level of care to the patient would be rendered invalid. Sutter Health strongly recommends reversing this directive and allowing hospitals to charge for the critical care level when the criteria used to make that determination indicates the patient should be at this level of care. If CMS created a 6th level of ED/Clinic care and eliminated the critical care terminology, this directive would be moot.

If CMS chooses to keep the critical care verbiage for hospitals and not move to the creation of a 6th level of care, then Sutter Health would like to recommend to CMS that the additional time for critical care, currently represented by 99292, should be changed to a payable status and not remain as bundled. CMS is adopting this logic for drug administration codes, why not for critical care? This level represents the highest level of care provided to a patient and a facility should be reimbursed for the additional time spent with a very labor intensive patient.

Sutter Health would also like to ask about reimbursement for trauma activation represented by revenue codes of 068x. Trauma services are very costly with no additional reimbursement opportunity. Could CMS please comment on when hospitals that provide this service might realize additional reimbursement?

Submitter : **Ms. Barbara Tauscher** **Date: 10/07/2006**

Organization : **The Gastroenterology Endoscopy Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2007 ASC Impact

CY 2007 ASC Impact

October 06, 2006

Mark B. McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; CY 2007 Update to the Ambulatory Surgical Center Covered Procedures List

Dear Dr. McClellan:

I am the Executive Director of The Gastroenterology Endoscopy Center, Inc, which has Endoscopy ASCs located in Oregon City and Tualatin, Oregon. Each year, our surgery centers provide over 1200 procedures to local Medicare beneficiaries. Medicare patients represent 20% percent of our business and ensuring appropriate payment for their services is vital to our ability to serve our community. Please accept the following comments regarding Section XVII of the proposed rule, which would make revisions to policies affecting ambulatory surgical centers for CY 2007. 71 Fed. Reg. 49505 (August 23, 2006).

I. Proposed ASC List Update Effective for Services Furnished On or After January 1, 2007

A. Criteria for Additions to or Deletions from the ASC List

I commend CMS for proposing to update the ASC list for CY 2007, but believe the update falls short by not making extensive revisions to the criteria used to determine which procedures may be reimbursed in the ASC setting. As a result, beneficiary access to ASC services will continue to be limited by arbitrary criteria in CY 2007.

1. The inclusionary ASC list should be abandoned.
The limited, inclusionary list of covered ASC procedures is no longer the best way to address the safety and appropriateness of ASC services. Within currently accepted standards of medical practice - in which vast numbers of procedures may be performed in a variety of outpatient settings - use of the ASC list has undesired consequences for the most optimal delivery of outpatient procedural services.
First, and most importantly, the ASC list limits the ability of physicians to select the site of service they believe is most clinically appropriate for their patients. A physician s assessment of the medical needs of the patient and the capabilities of the facility should determine whether a patient receives care in the ASC setting.
Second, the list limits Medicare beneficiaries access to procedures that many other patients routinely receive in ASCs. Private payers do not restrict the access of their insureds to ASC services. Decisions regarding the site of service are recognized to be the province of the insured s physician. As a result, several minimally invasive procedures not available to Medicare patients in the ASC setting, such as spinal disc decompression and laparoscopic cholecystectomy, are commonly performed for selected privately insured patients - at significant savings to the patient and to the insurer. As long as CMS continues to maintain an ASC list, Medicare beneficiaries access to appropriate services will always lag behind that of the private sector.
The ASC list should be abandoned. In its place, CMS should adopt the recommendations of the Medicare Payment Advisory Commission (MedPAC) and develop a list of services specifically excluded from coverage. In fact, CMS already has such an exclusionary list; for purposes of hospital outpatient payment under the Outpatient Prospective Payment System, CMS has developed and uses an inpatient only list. Because Medicare-certified ASCs have proven over the past two decades that they are capable of safely performing the same scope of services provided in hospital outpatient departments, this list may also be used to identify procedures excluded from coverage in ASCs.
Alternatively, if CMS develops a separate exclusionary list for ASCs, then that list should be based on the criteria identified by MedPAC in their March 2004 report.
Barbara Tauscher 971-224-2457

Submitter : **Ms. Janet Hieshetter** **Date: 10/08/2006**

Organization : **Dystonia Medical Research Foundation**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P-323-Attach-1.RTF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Kenneth Belitsis **Date:** 10/08/2006

Organization : Dr. Kenneth Belitsis

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am concerned about the proposed cut backs on the ASC. I believe this proposal, if passes, will be very detrimental to patient care. This proposal will force gastroenterologist to abandon such centers. These centers have proven themselves more efficient and more cost effective than hospital based endoscopy. In the long run, fewer colonoscopies that will be performed will mean more undetected colon cancers. The cost of trying to treat colon cancer dwarfs the cost of the colonoscopy. This will be the ultimate affect of this proposal. Please re-evaluate this proposal and vote against it. Thank you for your time.

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED BOYTON BEACH CA CENTER

CMS-1506-P-325-Attach-1.DOC

Boynton Beach Cancer Center

October 3, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P; Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates;

Dear CMS Administrator:

I appreciate the opportunity to provide comments on the CMS HOPPS proposed rule # CMS-1506-P. I am very concerned about the impact these new rates will have on breast conservation therapy in relation to the proposed assignment of 19296 and 19297 to new APCs.

CMS should continue with CPT codes 19296 and 19297 being assigned to New Technology APCs 1524 and 1523 respectively. The CMS proposed reassignment of these codes from New Technology APCs to clinical APCs in 2007 would result in considerable decreases in 2007 payment. The table below illustrates the reductions, ranging from –22.8% to –37.0%.

HCPCS Code	2006 APC	2006 Payment	2007 Proposed APC	2007 Proposed Payment	Payment Change 2006-2007	Percent Change 2006-2007
19296 Breast interstitial radiation treatment, delayed	1524	$3,250	0030	$2,508.17	($741.83)	**-22.8%**
19297 Breast interstitial radiation treatment, immediate	1523	$2,750	0029	$1,732.69	($1,017.31)	**-37.0%**

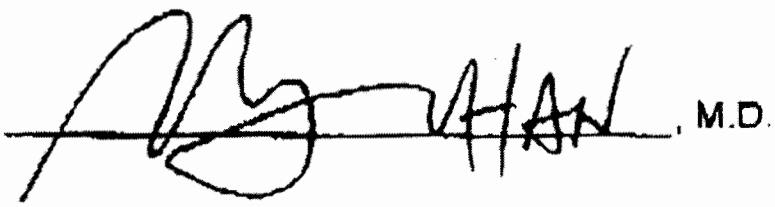
Should CMS finalize the proposed APC assignments, the cost of the device will surpass the proposed payment rate. This will severely limit our ability to offer this breast cancer treatment option to Medicare eligible women.

CMS should maintain 19296 and 19297 in the New Tech APCs 1524 and 1523 respectively so that it may collect claims data through calendar year 2006 and reevaluate reassignment to a more appropriate APC for 2008. These CPT codes are device-dependent and the APC assigned, must cover the cost of the device. Of note: the cost of the brachytherapy device is the same when implanted at time of lumpectomy or during a separate procedure.

Additionally, our facility purchases the radiation source to be used in breast conservation treatment. Our facility must be able to cover the costs of the radiation source so that we may continue to provide this less invasive, highly-effective cancer treatment to Medicare beneficiaries.

In closing, I recommend that breast brachytherapy codes 19296 and 19297 remain in their current New Technology APCs (1524 and 1523 respectively) for 2007 to allow the opportunity to collect additional claims data. I respectfully request that CMS heed my recommendations. I would like to continue servicing your Medicare beneficiaries.

Regards,



, M.D.

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, Director, Division of Outpatient Care
James Rubenstein, MD, Chairman, American College of Radiation Oncology
Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation Oncology
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons
W. Robert Lee, MD, President, American Brachytherapy Society

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED SCOTT STEINBERG GA

CMS-1506-P-326-Attach-1.DOC

#326

SURGICAL ASSOCIATES, LLC

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

Dear CMS Administrator,

Thank you for the opportunity to provide comments on file #CMS-1506-P for the CY 2007 / 2008 CMS proposed Hospital Outpatient Prospective Payment System (OPPS). I have concerns regarding your proposed changes.

I recommend Partial Breast Irradiation Therapy for carefully selected Breast Cancer patients. With Partial Breast Irradiation Therapy, a woman can complete her Radiation treatments in five days. The women are more compliant - which ultimately reduces her risk of breast cancer recurrence.

The reassignment of CPT codes 19296 & 19297 to APC #0030 is not sufficient payment for the catheter which is priced at $2,750. Our recommendation is for CPT codes 19296 & 19297 to remain under APC #1524 for at least one more year so additional data can be collected on this service.

Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

Respectfully,

Scott Steinberg, M.D.

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED MICHAEL QUINONES MD

CMS-1506-P-327-Attach-1.DOC

#321

SURGICAL ASSOCIATES, LLC

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

Respectfully,

Michael Quinones, M.D.

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
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Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED SIDNEY STAPLETON JR MD

CMS-1506-P-328-Attach-1.DOC

#325

SURGICAL ASSOCIATES, LLC

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

Respectfully,

Sidney L. Stapleton, Jr., M.D.

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
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Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED EUGENE HARRISON MD

CMS-1506-P-329-Attach-1.DOC

#329

SURGICAL ASSOCIATES, LLC

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

Eugene Harrison, M.D.

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED SURAJ MANACHERY MD

CMS-1506-P-330-Attach-1.DOC

AF330

SURGICAL ASSOCIATES, LLC

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Respectfully,

Suraj Menachery, M.D.

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED KEN MCARTHUR MD

CMS-1506-P-331-Attach-1.DOC

A331

SHACHNER & ZARAGOZA, M.D., P.A.
GENERAL & LAPAROSCOPIC SURGERY • SURGICAL ONCOLOGY
DIPLOMATES AMERICAN BOARD OF SURGERY

MARK S. SHACHNER, M.D., F.A.C.S.
BERNARD J. ZARAGOZA, M.D., F.A.C.S.
ALAN S. BASSIN, M.D., F.A.C.S
KENDRICK D. MCARTHUR, D.O.
MELVIN E. PANN, M.D., F.A.C.S.
JOCELYN C. GRENIER, PA-C, MMS

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED MARK SHACHNER MD

CMS-1506-P-332-Attach-1.DOC

SHACHNER & ZARAGOZA, M.D., P.A.
GENERAL & LAPAROSCOPIC SURGERY • SURGICAL ONCOLOGY
DIPLOMATES AMERICAN BOARD OF SURGERY

MARK S. SHACHNER, M.D., F.A.C.S.
BERNARD J. ZARAGOZA, M.D., F.A.C.S.
ALAN S. BASSIN, M.D., F.A.C.S
KENDRICK D. MCARTHUR, D.O.
MELVIN E. PANN, M.D., F.A.C.S.
JOCELYN C. GRENIER, PA-C, MMS

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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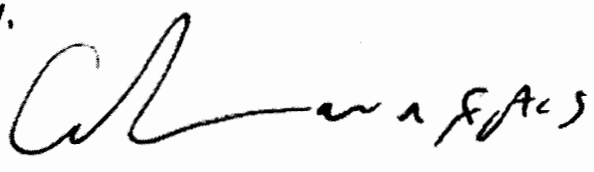
Respectfully,



cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy
SEE ATTACHED MELVIN PANN MD

CMS-1506-P-333-Attach-1.DOC

#333

SHACHNER & ZARAGOZA, M.D., P.A.
GENERAL & LAPAROSCOPIC SURGERY • SURGICAL ONCOLOGY
DIPLOMATES AMERICAN BOARD OF SURGERY

MARK S. SHACHNER, M.D., F.A.C.S.
BERNARD J. ZARAGOZA, M.D., F.A.C.S.
ALAN S. BASSIN, M.D., F.A.C.S
KENDRICK D. MCARTHUR, D.O.
MELVIN E. PANN, M.D., F.A.C.S.
JOCELYN C. GRENIER, PA-C, MMS

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

Dear CMS Administrator,

Thank you for the opportunity to provide comments on file #CMS-1506-P for the CY 2007 / 2008 CMS proposed Hospital Outpatient Prospective Payment System (OPPS). I have concerns regarding your proposed changes.

I recommend Partial Breast Irradiation Therapy for carefully selected Breast Cancer patients. With Partial Breast Irradiation Therapy, a woman can complete her Radiation treatments in five days. The women are more compliant - which ultimately reduces her risk of breast cancer recurrence.

The reassignment of CPT codes 19296 & 19297 to APC #0030 is not sufficient payment for the catheter which is priced at $2,750. Our recommendation is for CPT codes 19296 & 19297 to remain under APC #1524 for at least one more year so additional data can be collected on this service.

Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

Respectfully,

Melvin E. Pann, M.D.

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED BERNARD ZARAGOZA MD

CMS-1506-P-334-Attach-1.DOC

SHACHNER & ZARAGOZA, M.D., P.A.
GENERAL & LAPAROSCOPIC SURGERY • SURGICAL ONCOLOGY
DIPLOMATES AMERICAN BOARD OF SURGERY

MARK S. SHACHNER, M.D., F.A.C.S.
BERNARD J. ZARAGOZA, M.D., F.A.C.S.
ALAN S. BASSIN, M.D., F.A.C.S
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JOCELYN C. GRENIER, PA-C, MMS

October 4, 2006

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Department of Health and Human Services
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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED ALAN BASSIN MD

CMS-1506-P-335-Attach-1.DOC

#535

SHACHNER & ZARAGOZA, M.D., P.A.
GENERAL & LAPAROSCOPIC SURGERY • SURGICAL ONCOLOGY
DIPLOMATES AMERICAN BOARD OF SURGERY

MARK S. SHACHNER, M.D., F.A.C.S.
BERNARD J. ZARAGOZA, M.D., F.A.C.S.
ALAN S. BASSIN, M.D., F.A.C.S
KENDRICK D. MCARTHUR, D.O.
MELVIN E. PANN, M.D., F.A.C.S.
JOCELYN C. GRENIER, PA-C, MMS

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED ROBERT DONNOWAY MD

CMS-1506-P-336-Attach-1.DOC

#336

SURGICAL ONCOLOGY ASSOCIATES
OF
SOUTH FLORIDA, Inc.

Robert B. Donoway, M.D., F.A.C.S., F.S.S.O.
Arthur H. Pomerantz, M.D., Ph.D., F.A.C.S.
Gary M. Onik, M.D.
Associate

Practice Specializing in
Surgical Oncology and Breast Diseases
Breast Surgical Oncology
Thoracic Surgical Oncology
Endocrine and Advanced Laparoscopic Surgery
Minimally Invasive Image Guided Tumor Ablation Surgery
Genetic Cancer Counseling

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

Dear CMS Administrator,

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Robert B. Donoway, M.D., F.A.C.S., F.S.S.O.

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Senator Thad Cochran, Chairman, Senate Appropriations Committee
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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED ARMAND KATZ MD

CMS-1506-P-337-Attach-1.DOC

#337

CYPRESS SURGICAL ASSOCIATES
General Surgery, Surgical Oncology, Colon and Rectal Surgery
Advanced Laparoscopic and Minimally Invasive Procedures
Endocrine and Breast Surgery

Armand H. Katz, MD, FACS
Mufa T. Ghadiali, MD

Joseph J. Casey MD, FACS
John E. Roberts III, MD, FASCRS, FACS

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED MARY BETH TOMASELLI MD

CMS-1506-P-338-Attach-1.DOC

#328

Mary Beth Tomaselli, M.D.
Comprehensive Breast Center of Coral Springs
1283 University Drive
Coral Springs, Florida 33071
954-345-2718

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

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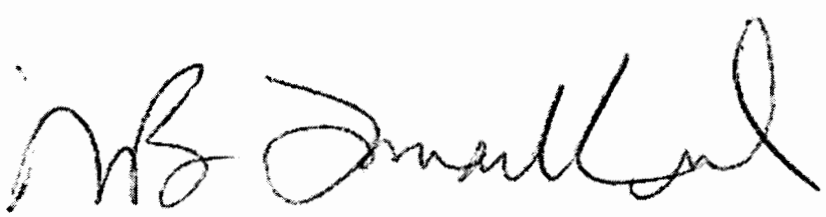

Mary Beth Tomaselli, MD

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

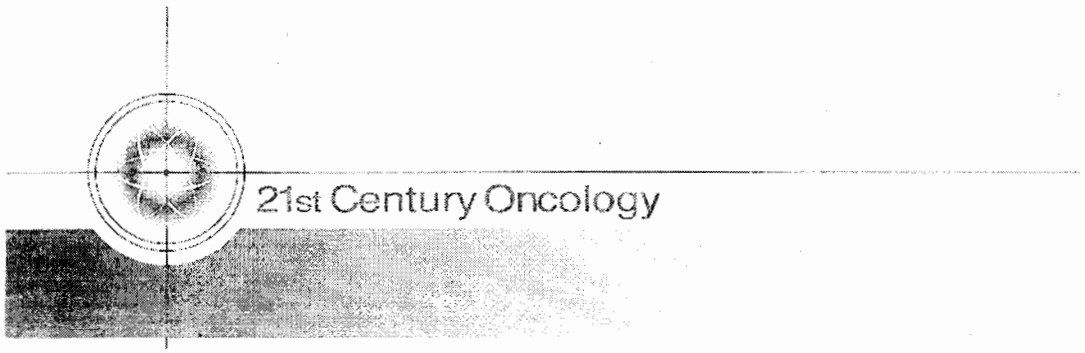
OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED PARTICK FRANCKE MD

CMS-1506-P-339-Attach-1.DOC

AT 339



October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED JOSEPH CASEY MD

CMS-1506-P-340-Attach-1.DOC

H 540

CYPRESS SURGICAL ASSOCIATES
General Surgery, Surgical Oncology, Colon and Rectal Surgery
Advanced Laparoscopic and Minimally Invasive Procedures
Endocrine and Breast Surgery

Armand H. Katz, MD, FACS
Mufa T. Ghadiali, MD

Joseph J. Casey MD, FACS
John E. Roberts III, MD, FASCRS, FACS

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED JOHN ROBERTS MD

CMS-1506-P-341-Attach-1.DOC

#341

CYPRESS SURGICAL ASSOCIATES
General Surgery, Surgical Oncology, Colon and Rectal Surgery
Advanced Laparoscopic and Minimally Invasive Procedures
Endocrine and Breast Surgery

Armand H. Katz, MD, FACS
Mufa T. Ghadiali, MD

Joseph J. Casey MD, FACS
John E. Roberts III, MD, FASCRS, FACS

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

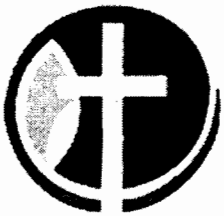
OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED ABDON MEDINA MD

CMS-1506-P-342-Attach-1.DOC

A392



Michael and Dianne Bienes Comprehensive Cancer Center
Holy Cross Hospital

October 3, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P; Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates;

Dear CMS Administrator:

I appreciate the opportunity to provide comments on the CMS HOPPS proposed rule # CMS-1506-P. I am extremely concerned about the impact these new rates will have on breast conservation therapy in relation to the proposed assignment of 19296 and 19297 to new APCs and the proposed new payment methodology for brachytherapy sources in 2007.

I highly recommend CMS continue with CPT codes 19296 and 19297 being assigned to New Technology APCs 1524 and 1523 respectively. The CMS proposed reassignment of these codes from New Technology APCs to clinical APCs in 2007 would result in considerable decreases in 2007 payment. The table below illustrates the reductions, ranging from –22.8% to –37.0%.

HCPCS Code	2006 APC	2006 Payment	2007 Proposed APC	2007 Proposed Payment	Payment Change 2006-2007	Percent Change 2006-2007
19296 Breast interstitial radiation treatment, delayed	1524	$3,250	30	$2,508.17	($741.83)	**-22.8%**
19297 Breast interstitial radiation treatment, immediate	1523	$2,750	29	$1,732.69	($1,017.31)	**-37.0%**

Should CMS finalize the proposed APC assignments, the cost of the device will surpass the proposed payment rate. This will severely limit our ability to offer this breast cancer treatment option to Medicare eligible women.

CMS should maintain 19296 and 19297 in the New Tech APCs 1524 and 1523 respectively so that it may collect claims data through calendar year 2006 and reevaluate reassignment to a more appropriate APC for 2008. These CPT codes are device-dependent and the APC assigned, must cover the cost of the device. Of note: the cost of the brachytherapy device is the same when implanted at time of lumpectomy or during a separate procedure.

Additionally, our hospital purchases the radiation source to be used in breast conservation treatment and bills C1717 for the HDR Iridium 192. It is necessary to continue with the cost to charge ratio payment methodology in order to continue providing breast conservation treatment to our Medicare patients. Our hospital must be able to cover the costs of the radiation source so that we may continue to provide this less invasive, highly-effective cancer treatment to Medicare beneficiaries.

In closing, I recommend:

1. that breast brachytherapy codes 19296 and 19297 remain in their current New Technology APCs (1524 and 1523 respectively) for 2007 to allow the opportunity to collect additional claims data.

2. that CMS continue current payment methodology for all brachytherapy sources at hospital charges adjusted to cost calendar years 2007 and 2008.

I respectfully request that CMS heed my recommendations. I would like to continue servicing your Medicare beneficiaries.

Regards,

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
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Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, MPH, Director, Division Outpatient Services
James Rubenstein, MD, Chairman, American College of Radiation Oncology
Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation Oncology
W. Robert Lee, MD, President, American Brachytherapy Society

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED NURIA LAWSON MD

CMS-1506-P-343-Attach-1.DOC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED ROBERT COMPERATORE MD

CMS-1506-P-344-Attach-1.DOC

H 344

Robert Comperatore
M.D., F.A.C.S.
Diplomate American Board of Surgery
General and Advanced Laparoscipic Surgery
Clinical Associate Professor
Nova Southeastern University

7150 WEST 20TH AVENUE
SUITE 215
HIALEAH, FL 33016
PALMED BUILDING
(305) 558-4428

801 N. FLAMINGO RD.
SUITE 405
PEMBROKE PINES, FL 33028
MEMORIAL HOSPITAL
WEST OFFICE BUILDING
(954) 437-9590

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

Dear CMS Administrator,

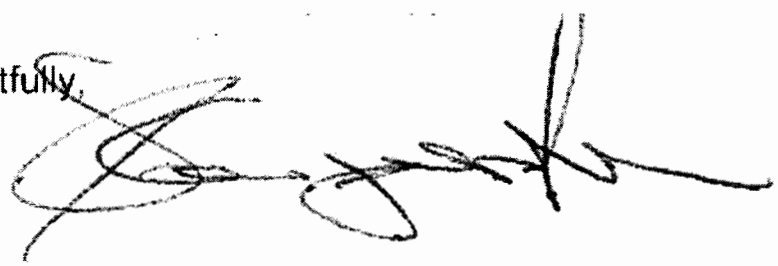
Thank you for the opportunity to provide comments on file #CMS-1506-P for the CY 2007 / 2008 CMS proposed Hospital Outpatient Prospective Payment System (OPPS). I have concerns regarding your proposed changes.

I recommend Partial Breast Irradiation Therapy for carefully selected Breast Cancer patients. With Partial Breast Irradiation Therapy, a woman can complete her Radiation treatments in five days. The women are more compliant - which ultimately reduces her risk of breast cancer recurrence.

The reassignment of CPT codes 19296 & 19297 to APC #0030 is not sufficient payment for the catheter which is priced at $2,750. Our recommendation is for CPT codes 19296 & 19297 to remain under APC #1524 for at least one more year so additional data can be collected on this service.

Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

Respectfully,



cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED NURIA LAWSON MD

CMS-1506-P-345-Attach-1.DOC

#345

Nuria M. Lawson, M.D.
General & Laparoscopic Surgery

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED LAWRENCE BLACK DO, FACOS

CMS-1506-P-346-Attach-1.DOC

#351

LAWRENCE R. BLACK, D.O., F.A.C.O.S. GENERAL SURGERY

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Respectfully,

Lawrence Black

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
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Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

see attached Jose Manibo md

CMS-1506-P-347-Attach-1.DOC

#347

SURGICAL SPECIALISTS
OF SOUTHWEST FLORIDA, P.A.
DIPLOMATES / AMERICAN BOARD OF SURGERY
AND VASCULAR LABORATORY

GORDON D. BURTCH, MD, FACS
General, Vascular & Transplant Surgery

AJAY KALRA, MD
General, Vascular & Endovascular Surgery

JOSE MANIBO, MD
General Surgery

ANTHONY J. D'ANGELO, MD, FACS
General and Vascular Surgery

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
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Baltimore, MD 21244-1850

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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED DENISE SANDERSON MD

CMS-1506-P-348-Attach-1.DOC

#348

The Breast Care Center
of The Treasure Coast

James J. Vopal, M.D., F.A.C.S.
Denise Ortega Sanderson, M.D.
Gina Bradley, A.R.N.P.

801 SE Osceola Street - Stuart, Florida 34994
(772) 220-4050 - Fax (772) 220-0502

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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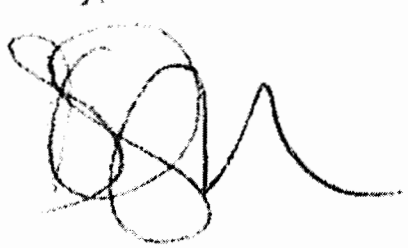

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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

see attached James Vopal MD

CMS-1506-P-349-Attach-1.DOC

#349

The Breast Care Center
of the Treasure Coast

James J. Vopal, M.D., F.A.C.S.
Denise Ortega Sanderson, M.D.
Gina Bradley, A.R.N.P.

801 SE Osceola Street - Stuart, Florida 34994
(772) 220-4050 Fax (772) 220-0502

October 4, 2006

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Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-1850

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Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Nurse Practitioner**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

see attached Gina Bradley ARNP

CMS-1506-P-350-Attach-1.DOC

#2571

The Breast Care Center
at The Treasure Coast

James J. Vopal, M.D., F.A.C.S.
Denise Ortega Sanderson, M.D.
Gina Bradley, A.R.N.P.

808 SE Osceola Street - Stuart, Florida 34994
(772) 220-4050 - Fax (772) 220-0503

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

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Respectfully,

Gina M Bradley ARNP
Gina M. Bradley, ARNP

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

see attached lacostra md

CMS-1506-P-351-Attach-1.DOC

#2551

Women's Breast Care Center, Inc.

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

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Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED DAVID OWEN MD

CMS-1506-P-352-Attach-1.DOC

#352

David H. Owen, M.D.
Breast Cancer Surgeon
2240 Woolbright Road #405 Boynton Beach, FL 33426 (561) 733-6565
Screening Diagnosis Consultation Second Opinion Source Treatment Lifetime Follow-up
The Breast Care for You!!!

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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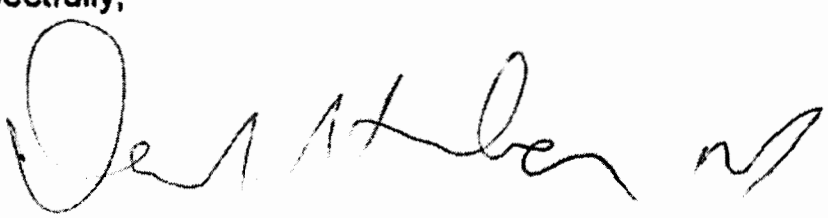

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Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy
SEE ATTACHED DONNA KELBAN MD

CMS-1506-P-353-Attach-1.DOC

Donna H. Kleban, M.D., F.A.C.S., P.A.

1395 State Road 7
Suite 410
Wellington, FL 33414
Telephone (561)791-3301 ♦ Facsimile (561)791-7745

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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Respectfully,

Donna H. Kleban, M.D., FACS

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
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Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED KISHORE DASS MD

CMS-1506-P-354-Attach-1.DOC

H254

KISHORE K. DASS, M.D.

P.O. Box 212080
Royal Palm Beach, FL 33421
Phone: (561) 753-2688
Fax: (561) 472-2512

October 3, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P; Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates;

Dear CMS Administrator:

I appreciate the opportunity to provide comments on the CMS HOPPS proposed rule # CMS-1506-P. I am very concerned about the impact these new rates will have on breast conservation therapy in relation to the proposed assignment of 19296 and 19297 to new APCs.

CMS should continue with CPT codes 19296 and 19297 being assigned to New Technology APCs 1524 and 1523 respectively. The CMS proposed reassignment of these codes from New Technology APCs to clinical APCs in 2007 would result in considerable decreases in 2007 payment. The table below illustrates the reductions, ranging from –22.8% to –37.0%.

HCPCS Code	2006 APC	2006 Payment	2007 Proposed APC	2007 Proposed Payment	Payment Change 2006-2007	Percent Change 2006-2007
19296 Breast interstitial radiation treatment, delayed	1524	$3,250	0030	$2,508.17	($741.83)	**-22.8%**
19297 Breast interstitial radiation treatment, immediate	1523	$2,750	0029	$1,732.69	($1,017.31)	**-37.0%**

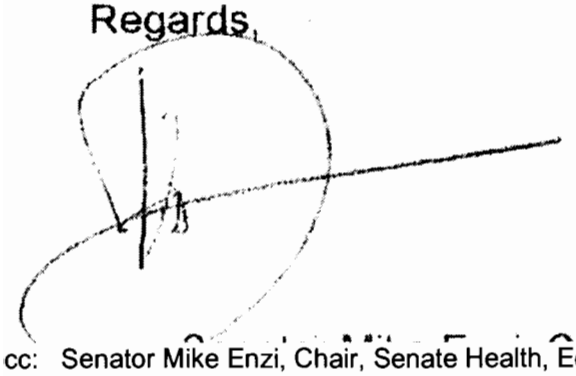
Should CMS finalize the proposed APC assignments, the cost of the device will surpass the proposed payment rate. This will severely limit our ability to offer this breast cancer treatment option to Medicare eligible women.

CMS should maintain 19296 and 19297 in the New Tech APCs 1524 and 1523 respectively so that it may collect claims data through calendar year 2006 and reevaluate reassignment to a more appropriate APC for 2008. These CPT codes are device-dependent and the APC assigned, must cover the cost of the device. Of note: the cost of the brachytherapy device is the same when implanted at time of lumpectomy or during a separate procedure.

Additionally, our facility purchases the radiation source to be used in breast conservation treatment. Our facility must be able to cover the costs of the radiation source so that we may continue to provide this less invasive, highly-effective cancer treatment to Medicare beneficiaries.

In closing, I recommend that breast brachytherapy codes 19296 and 19297 remain in their current New Technology APCs (1524 and 1523 respectively) for 2007 to allow the opportunity to collect additional claims data. I respectfully request that CMS heed my recommendations. I would like to continue servicing your Medicare beneficiaries.

Regards,



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Carol Bazell, MD, Director, Division of Outpatient Care
James Rubenstein, MD, Chairman, American College of Radiation Oncology
Prabhakar Tripuraneni, MD, Chair, American Society of Therapeutic Radiation Oncology
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons
W. Robert Lee, MD, President, American Brachytherapy Society

Submitter : **Date: 10/09/2006**

Organization : **American Academy of Neurology**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1506-P-355-Attach-1.DOC

#355

1080 Montreal Avenue
St. Paul, Minnesota 55116

tel: 651.695.1940
fax: 651.695.2791

www.aan.com

October 5, 2006

Mark B. McClellen, PhD
Administrator, Centers for Medicare and Medicaid Services

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P; CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: file codes CMS-1506-P; CMS-4125-P

Dear Dr. McClellen,

The American Academy of Neurology (AAN), representing over 19,000 neurologists and neuroscientists, is pleased to submit these comments on the rule proposed by CMS entitled: *Medicare Program: Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; CY 2007 Update to the Ambulatory Surgical Center Covered Procedures List; Ambulatory Surgical Center Payment System and CY 2008 Payment Rates; Medicare Administrative Contractors; and Reporting Hospital Quality Data for FY 2008 Inpatient Prospective Payment System Annual Payment Update Program—HCAHPS Survey, SCIP, and Mortality* [CMS-1506-P; CMS-4125-P] Federal Register, August 23, 2006. We appreciate this opportunity to comment on the issues raised in your proposed rule. The AAN would like to offer remarks in two areas:

- Magnetoencephalography (MEG) Services
- Drug Administration—IVIG

Magnetoencephalography (MEG) Services

MEG is a non-invasive procedure that helps identify seizure activity or evoked sensory activity, which can be overlaid onto MRI images of the brain. It is principally used for determining the appropriateness of surgery in epilepsy patients whose seizures cannot be well controlled by drug therapy. It also has application for certain other patients scheduled for a neurosurgical procedure of the brain. MEG is used to locate the precise regions of the brain responsible for sensation, movement, vision and hearing, relative to the surgical target. The images and data generated help guide the neurosurgeon and assure that parts of the brain critical to these functions are not injured.

In the proposed rule, CMS has moved the MEG codes out of the new technology category into clinical APCs. CPT Code 95965 was placed into a new APC category, APC 0038, Spontaneous MEG, at a rate of $3,155. According to the rule, there were 23 claims for this service, which CMS felt was sufficient for determining a payment level for Code 95965. We support the establishment of a separate APC for this code and CMS' proposed payment level.

CMS is proposing to assign Codes 95966 and 95967 to APC 0209, Extended EEG and Sleep Studies, Level II. This APC has a payment rate of $706.89. CMS had less than five claims for these two MEG codes (three for Code 95966 and one for Code 95967). With such a small number of claims, we are concerned that the placement of Code 95966 in APC 0209 is not appropriate. We recognize that that there are some similarities between MEG studies and extended EEGs and sleep studies, but with only three claims for Code 95966 a true cost comparison can not be made.

We do not agree with CMS that the resources required to provide Code 95966 are at all similar to the costs of providing the EEG and sleep testing codes assigned to APC 0209. The highest volume codes in this APC are the polysomnography codes 95810 and 95811. Under the physician fee schedule, CMS estimated the total equipment costs for providing polysomnography at less than $100,000. In contrast, the cost of purchasing a MEG system is in excess of $2.5 million. The annual maintenance on this equipment is about $100,000. In addition to the MEG equipment costs being substantially higher, because of the highly specialized nature of these services MEG equipment is utilized to a much lower level than the EEG and sleep testing equipment. We strongly urge CMS to establish a separate APC for Code 95966 at a payment rate set at 50 percent of the rate for Code 95965 or approximately $1,550 or maintain the current new technology assignment of Code 95966 to APC 1514 with a payment rate of $1250.

Code 95967 is an add-on code always used in conjunction with 95965 or 95966. It is less costly to provide than the other MEG services. Even though there was only one claim for this code, we concur with CMS' proposal to add 95967 to APC 0209 until additional claims data is available.

Drug Administration—IVIG

The continuance of the temporary G-code G0332 is essential to cover pre-administration-related services for the infusion of IVIG. Patients often require pre-administration care such as pre-medication with acetominophen, steroids, and anti-emetic medications. In addition, patients must have an interval history and vital signs taken prior to IVIG infusion. Thus, the AAN urges CMS to consider the extension of G0332.

The AAN appreciates the opportunity to comment on this proposed rule and continues to be grateful for your consideration of our remarks. If you have any questions regarding the above comments, please contact Katie Kuechenmeister at the AAN offices at kkuechenmeister@aan.com or by phone at 651-695-2783.

Sincerely,

Laura B Powers MD

Laura B. Powers, MD
Chair, Medical Economics and Management Committee

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED WENGLER MD

CMS-1506-P-356-Attach-1.DOC

#C3.6

FRANK R. BRIGGS, M.D.
JAMES KEVIN CHANDLER, M.D.
H. RICHARD JOHNSON, M.D., *Emeritus*
STEVEN J. PATTERSON, M.D.
PAT H. SCANLON, JR., M.D.
RICHARD L. YELVERTON, M.D.
RICHARD L. YELVERTON, JR., M.D.

Diplomats of the American Board of Surgery
Fellows of the American College of Surgeons

LAKELAND SURGICAL CLINIC, PLLC

General Surgery *Thoracic Surgery* *Breast Surgery*

October 4, 2006

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1506-P for Hospital Outpatient Prospective Payment System (OPPS) Rule Breast Brachytherapy

Dear CMS Administrator,

Thank you for the opportunity to provide comments on file #CMS-1506-P for the CY 2007 / 2008 CMS proposed Hospital Outpatient Prospective Payment System (OPPS). I have concerns regarding your proposed changes.

I recommend Partial Breast Irradiation Therapy for carefully selected Breast Cancer patients. With Partial Breast Irradiation Therapy, a woman can complete her Radiation treatments in five days. The women are more compliant - which ultimately reduces her risk of breast cancer recurrence.

The reassignment of CPT codes 19296 & 19297 to APC #0030 is not sufficient payment for the catheter which is priced at $2,750. Our recommendation is for CPT codes 19296 & 19297 to remain under APC #1524 for at least one more year so additional data can be collected on this service.

Thank you for implementing this recommendation. We would like to continue servicing your Medicare patients with breast brachytherapy services when clinically indicated.

Respectfully,

(WENGLER
509 RIVERSIDE DRIVE
STUART, FL 34996

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, Director, Division of Outpatient Care
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED KEVIN CHANDLER MD

CMS-1506-P-357-Attach-1.DOC

#251

FRANK R. BRIGGS, M.D.
JAMES KEVIN CHANDLER, M.D.
H. RICHARD JOHNSON, M.D., *Emeritus*
STEVEN J. PATTERSON, M.D.
PAT H. SCANLON, JR., M.D.
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Diplomats of the American Board of Surgery
Fellows of the American College of Surgeons

LAKELAND SURGICAL CLINIC, PLLC

General Surgery *Thoracic Surgery* *Breast Surgery*

Attention: CMS-1506-P; Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates;

Dear Administrator:

We appreciate the opportunity to provide comments on CMS-1506-P. We would like to highlight the negative impact these proposed rates will have on breast conservation therapy. We have two major areas of concern in the HOPPS proposed rule, specifically:

1) the proposed assignment of 19296 and 19297 to new APCs
2) the proposed payment methodology for brachytherapy sources in 2007.

CMS implemented breast brachytherapy CPT codes 19296 and 19297 on January 1, 2005 and assigned these codes to New Technology APCs 1524 and 1523 respectively. CMS proposes to reassign these codes from New Technology APCs to clinical APCs in 2007. The CMS proposed APC assignment for CPT Codes 19296 and 19297 would result in significant decreases in 2007 payment. The table below illustrates the reductions, ranging from –22.8% to –37.0%.

HCPCS Code	2006 APC	2006 Payment	2007 Proposed APC	2007 Proposed Payment	Payment Change 2006-2007	Percent Change 2006-2007
19296 Breast interstitial radiation treatment, delayed	1524	$3,250	0030	$2,508.17	($741.83)	**-22.8%**
19297 Breast interstitial radiation treatment, immediate	1523	$2,750	0029	$1,732.69	($1,017.31)	**-37.0%**

Should CMS finalize the proposed APC assignments, it will limit our ability to offer this breast cancer treatment option to Medicare eligible women. The cost of the device will surpass the proposed payment rate.

CMS should maintain 19296 and 19297 in the New Tech APCs 1524 and 1523 respectively so that it may collect claims data through calendar year 2006 and reevaluate reassignment to a more appropriate APC for 2008. These CPT codes are device-dependent and the APC they are assigned to **must** cover the cost of the device. Of note: the cost of the brachytherapy device is the same when implanted at time of lumpectomy or during a separate procedure.

Breast brachytherapy CPT codes 19296 and 19297 are classified as device-dependent procedures. The codes rely on the use of a high-cost device that is bundled into the procedure payment. APC 648 Breast Reconstruction with Prosthesis includes other similar procedures to those of 19296 and 19297. The similarities are not only clinical but also similar in device cost. Should CMS discontinue the assignment of 19296 and 19297 in new tech APCs, an alternative request is for both CPT codes to be reclassified to APC 648.

In closing, I recommend that breast brachytherapy codes 19296 and 19297 remain in their current New Technology APCs (1524 and 1523 respectively) for 2007 to allow CMS the opportunity to collect additional claims data. Alternatively, I recommend that CPT codes 19296 and 19297 be assigned to clinical APC 648 Breast Reconstruction with Prosthesis. To appropriately capture all procedures in APC 648, it is also recommended that CMS revise the group title from Breast Reconstruction with Prosthesis to Level IV Breast Surgery.

Thank you in advance for your assistance,

J Kevin Chandler MD

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
Senator Sam Brownback, Co-Chair, Senate Cancer Committee
Senator Thad Cochran, Chairman, Senate Appropriations Committee
Representative Michael Bilirakis, Energy and Commerce Health Subcommittee
Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
Representative Katherine Harris, Member House Cancer Caucus
Representative Ileana Ros-Lehtinen, Vice Chair, Congressional Caucus for Women's Issues
Carol Bazell, MD, Director, Division of Outpatient Care
Carolyn Mullen, Deputy Director, Division of Practitioner Service
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Date: 10/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

OPPS: Brachytherapy

OPPS: Brachytherapy

SEE ATTACHED STEVEN PATTERSON MD

CMS-1506-P-358-Attach-1.DOC

#255

FRANK R. BRIGGS, M.D.
JAMES KEVIN CHANDLER, M.D.
H. RICHARD JOHNSON, M.D., *Emeritus*
STEVEN J. PATTERSON, M.D.
PAT H. SCANLON, JR., M.D.
RICHARD L. YELVERTON, M.D.
RICHARD L. YELVERTON, JR., M.D.

Diplomats of the American Board of Surgery
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LAKELAND SURGICAL CLINIC, PLLC

General Surgery *Thoracic Surgery* *Breast Surgery*

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Thank you in advance for your assistance,

cc: Senator Mike Enzi, Chair, Senate Health, Education, Labor and Pensions Committee
Senator Dianne Feinstein, Co-Chair, Senate Cancer Committee
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Representative Ginny Brown-Waite, Co-Chair, Congressional Caucus for Women's Issues
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Carol Bazell, MD, Director, Division of Outpatient Care
Carolyn Mullen, Deputy Director, Division of Practitioner Service
Helen Pass, MD, FACS, President, American Society of Breast Surgeons
Mark A. Malangoni, MD, FACS, Chair, American College of Surgeons

Submitter : **Tehjan Martin** **Date: 10/09/2006**

Organization : **Louisiana Association for Ambulatory Healthcare**

Category : **Other Health Care Provider**

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

LOUISIANA ASSOCIATION FOR AMBULATORY HEALTHCARE
619 North Main Street
Jennings, LA 70546
WWW.LAAH.ORG

Date: August 28, 2006

FILE CODE: CMS-1506-P PARTIAL HOSPITALIZATION
Re: Position Paper For LAAH on CMS-1506-P Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates Proposed Rule

In response to the Proposed Rule for Medicare Outpatient Prospective Payment for 2007 the Louisiana Association has the following comments and concerns.

The proposed rule referenced above continues to place extreme hardship on providers of Partial Hospitalization Programs. The rate proposed for 2007 once again falls below the actual cost of providing such services. CMS has proposed a gross APC of $208.27 for a day of services in a partial hospitalization program, which results in a net payment of approximately $145.00 for most Louisiana providers due to wage indexing. This is the third consecutive year of cuts for partial program mental health services which have totaled 30% over the last 3 years (2007-15.31%, 2006-12.59%, 2005-1.91%). These severe cuts, when most outpatient services received increases over the last 3 years, indicates that there are obvious issues with the proper setting of the APC rates for a day of partial care. These rates are insufficient to cover the cost of caring for an acutely ill person with mental illness. The current standard of Practice for Partial Hospitalization Programs is an average of 4-5 professional services per day. Services provided in a partial hospitalization program are provided both on a group and individual basis. Partial Hospital Programs require extensive amounts of professional services, inclusive of nursing, social work, therapy, ancillary services and psychiatry.

CMS noted in the final rule that they would accumulate appropriate data and determine if refinements to the per diem methodology were warranted. The current proposed rule once again acknowledges that appropriate cost data from CMHC s and hospitals has not been utilized due to aberrant data. The proposed cut of approximately 15% is not reflective of the cost pattern for the freestanding CMHC partial programs in our association. Both last year and this year CMS acknowledges that appropriate cost finding data was not available; therefore recommending 15% cuts for both years. However, CMS did appropriately cost find and set the rate for the components of the psychiatric services rendered in a partial program.

COMMENT 1 - DECREASE IN PARTIAL HOSPITAL PAYMENT BY 15% WHILE LOUISIANA PARTIAL COSTS INCREASED SUBSTANTIALLY

Louisiana has seen an unprecedented increase over the past year in costs for staffing, repairs and maintenance, supplies and insurance.

In the aftermath of Hurricanes Rita and Katrina in 2005, the cost of doing business in Louisiana has risen substantially. Insurance rates across the State have risen from 50-200% (Insurance Journal 10/24/2006), Nursing Salaries have increased by 10-15% (Louisiana Nurses Association, 2005), use of high cost staffing agencies have increased by 25% and cost for labor has increased by 7.4% Statewide and 28.7% in New Orleans (US Bureau of Labor and Statistics 4th Quarter 2005). Louisiana has lost 2046 RN s by application for change of address to another State since the storms (Louisiana State Board of Nursing, 2005). This added to an already strained nursing supply has substantially increased labor costs.

The proposed wage indexes in both Louisiana and Mississippi have been lowered post hurricane instead of adjusted upward. This results in a much lower payment rate for Louisiana and Mississippi. The wage index decrease makes the assumption that the cost of labor has actually decreased since the hurricanes. That would mean that despite the biggest shortage(continued)

Submitter : Mrs. Katherine Wittenmyer **Date:** 10/09/2006

Organization : American Therapeutic Corporation

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P-360-Attach-1.TXT

#360

I am writing as a Mental Health Provider, asking to delay finalizing the new 2007 rates until the 2006 cost reports are fully reviewed. The impact of the 2006 rates were felt, as PHP services are extremely important to the welfare of these patients who are seriously and persistently mentally ill. The proposed 2007 rate, I believe is insufficient to maintain the level of services that CMS regulations require be provided by PHPs.

Thank you for your consideration,
Katherine Wittenmyer, LMHC

Submitter : Tehjan Martin **Date:** 10/09/2006

Organization : Louisiana Association for Ambulatory Healthcare

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1506-P-361-Attach-1.DOC

CMS-1506-P-361-Attach-2.DOC

#2361

LOUISIANA ASSOCIATION FOR AMBULATORY HEALTHCARE
619 North Main Street
Jennings, LA 70546
WWW.LAAH.ORG

Date: August 28, 2006

FILE CODE: CMS-1506-P PARTIAL HOSPITALIZATION
Re: Position Paper For LAAH on CMS-1506-P Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates – Proposed Rule

In response to the Proposed Rule for Medicare Outpatient Prospective Payment for 2007 the Louisiana Association has the following comments and concerns.

The proposed rule referenced above continues to place extreme hardship on providers of Partial Hospitalization Programs. The rate proposed for 2007 once again falls below the actual cost of providing such services. CMS has proposed a gross APC of $208.27 for a day of services in a partial hospitalization program, which results in a net payment of approximately $145.00 for most Louisiana providers due to wage indexing. This is the third consecutive year of cuts for partial program mental health services which have totaled 30% over the last 3 years (2007-15.31%, 2006-12.59%, 2005-1.91%). These severe cuts, when most outpatient services received increases over the last 3 years, indicates that there are obvious issues with the proper setting of the APC rates for a day of partial care. These rates are insufficient to cover the cost of caring for an acutely ill person with mental illness. The current standard of Practice for Partial Hospitalization Programs is an average of 4-5 professional services per day. Services provided in a partial hospitalization program are provided both on a group and individual basis. Partial Hospital Programs require extensive amounts of professional services, inclusive of nursing, social work, therapy, ancillary services and psychiatry.

CMS noted in the final rule that they would accumulate appropriate data and determine if refinements to the per diem methodology were warranted. The current proposed rule once again acknowledges that appropriate cost data from CMHC's and hospitals has not been utilized due to aberrant data. The proposed cut of approximately 15% is not reflective of the cost pattern for the freestanding CMHC partial programs in our association. Both last year and this year CMS acknowledges that appropriate cost finding data was not available; therefore recommending 15% cuts for both years. **However, CMS did appropriately cost find and set the rate for the components of the psychiatric services rendered in a partial program.**

COMMENT I - DECREASE IN PARTIAL HOSPITAL PAYMENT BY 15% WHILE LOUISIANA PARTIAL COSTS INCREASED SUBSTANTIALLY

Louisiana has seen an unprecedented increase over the past year in costs for staffing, repairs and maintenance, supplies and insurance.

In the aftermath of Hurricanes Rita and Katrina in 2005, the cost of doing business in Louisiana has risen substantially. Insurance rates across the State have risen from 50-200% (Insurance Journal 10/24/2006), Nursing Salaries have increased by 10-15% (Louisiana Nurses Association, 2005), use of high cost staffing agencies have increased by 25% and cost for labor has increased by 7.4% Statewide and 28.7% in New Orleans (US Bureau of Labor and Statistics 4th Quarter 2005). Louisiana has lost 2046 RN's by application for change of address to another State since the storms (Louisiana State Board of Nursing, 2005). This added to an already strained nursing supply has substantially increased labor costs.

The proposed wage indexes in both Louisiana and Mississippi have been lowered post hurricane instead of adjusted upward. This results in a much lower payment rate for Louisiana and Mississippi. The wage index decrease makes the assumption that the cost of labor has actually decreased since the hurricanes. That would mean that despite the biggest shortage in staffing for hospitals in the past 20 years as well as the loss of professional and paraprofessional staff, salaries have gone down. **Any employer in the Gulf Coast states can verify that this is not correct**. Wages have increase substantially.

COMMENT II - PAYMENT FOR PARTIAL HOSPITALIZATION VERSUS OUTPATIENT

The Payment for Partial Hospitalization Services includes a full program, inclusive of Nursing Staff, Psychiatrists, Medical Doctors, Psychologists, Masters Prepared Therapists, Chemical Dependency Counselors, Activity Therapists, Occupational Therapists and Medical Technicians. All therapies provided are included in the one daily rate for APC 033.

In contrast, Outpatient Hospital Psychiatric Services do not require a multidisciplinary team, there are no requirements for nursing staff, and services may consist of one Psychiatrist and one Therapist. In addition, the criteria for admission for patients treated at this level are much less than for PHP, resulting in a much lower patient acuity.

We clearly believe the rates for PHP should be adequately set to reimburse providers appropriate for the setting and level of care. Partial Hospitalization Programs should be reimbursed at a minimum, the average payment rates set for Psychiatric Outpatient Services. CMS acknowledges that they do have appropriate cost finding for these individual outpatient codes. (HCPCS 90801-90862 or APC 322-325)

CMS has clearly defined what a partial day of service must include and local medical review policy takes that a step further. Detailed below are two tables reflective of a typical day of services offered in a partial day program utilizing the outpatient psychiatric service rates proposed by CMS.

TYPICAL DAY 1

HCPCS	APC	DESCRIPTION	RATE
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 66.40
90818	323	INDIVIDUAL PSYCHOTHERAPY SESSION	$105.68
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 66.40
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 66.40
TOTAL		**TOTALS FOR PARTIAL DAY SERVICES**	**$304.88**

TYPICAL DAY 2

HCPCS	APC	DESCRIPTION	RATE
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 66.40
90818	323	INDIVIDUAL PSYCHOTHERAPY SESSION	$105.68
90853	324	FAMILY THERAPY SESSION	$135.95
TOTAL		**TOTALS FOR PARTIAL DAY SERVICES**	**$308.03**

In addition to these core services, partial programs provide on call services to clients 24 hours a day 7 days per week. The typical partial services program day tables above yield an average componetized rate of $306. These component costs are not reduced when given in a partial setting. If anything, they can run higher due to the inability to share costs like hospital programs can. How can CMS propose a daily rate of $208.27 for the intense services offered?

QUESTIONS FROM LAAH TO CMS

1. DO YOU HAVE ADEQUATE DOCUMENTATION THAT THE WAGE INDEX FOR LOUISIANA – POST HURRICANES KATRINA AND RITA SHOULD BE DECREASED? ALL OF OUR ACTUAL DATA SHOW OTHERWISE.
2. ARE THE 2007 PROPOSED APC RATES FOR PSYCHIATRIC OUTPATIENT SERVICES CODES APC 322-325 (HCPCS 90801-90862) PROPERLY SET AND BASED UPON SUBSTANTIATED DATA?
3. DO YOU RECOGNIZE THAT A PARTIAL DAY PROGRAM IS MORE INTENSE THAN AN OUTPATIENT PSYCHIATRIC SERVICE AND ACTUALLY IS COMPRISED OF A MINIMUM OF 3-4 INTENSE SERVICES?
4. IF A PARTIAL DAY PROGRAM IS OFFERING 3-4 SERVICES THAT YOU DO HAVE ADEQUATE COST DATA ON WITH APPROPRIATE RATES COMPUTED, WHY CAN'T YOU SIMPLY CALCULATE A PARTIAL DAY COST BASED UPON YOUR ADEQUATE COST DATA FOR THE PSYCHIATRIC SERVICES OFFERED?
5. WHY WERE NO LOUISIANA CMHC/PARTIAL FREESTANDING PROGRAMS CONSIDERED IN YOUR IMPACT STATEMENT? ISN'T THAT REQUIRED BY REGULATION?

Once again, we are asking your consideration to leave the APC rate for code 033 at the 2006 rate or set it as a total of 4 of your calculated outpatient psychiatric component costs. In either case, this would not equate to a 15% cut.

We appreciate your consideration of my comments.

Louisiana Association for Ambulatory Healthcare