Submitter : Dr. robert meyer **Date:** 07/07/2006

Organization : hospital internal medicine specialist

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an internal medicine physician who practices hospital medicine. I would like to urge you to continue to work towards raising the reimbursement for the cognitive portion of the rvsu. As the population continues to age the medical complexity of the decesion making becomes more and more difficult. I am seeing a sicker population of inpatients with more and more complex medical and social issues. These services are just as important as the surgeon who takes out the patients gallbladder. I believe these services are underappreciated and under compensated. In order to continue to attract young and competent physicans into primary care, we must make the reimbursement competitive. Please consider adjusting the reimburement rates for medicare and medicare. Thanks.

Submitter : **Dr. Dawn Brezina** **Date: 07/07/2006**

Organization : **Durham Regional Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

July 7, 2006
Dawn Brezina, MD
2101 Chelsea Drive NW
Wilson, NC 27896
dawnbrezina@hotmail.com

Dear Sirs:

This letter is in support of the proposed increase in reimbursement (increase RVUs and evaluation and management) for medical services provided by primary care physicians. This legislation is critical to the continuation of many primary care practices.

Financial pressures in primary care are intense and increasing. Overhead costs relentlessly go up computer costs, personnel expenses, physical structure costs, insurance costs with almost no way to commensurately increase income. The only way to increase income is to see more patients. This works to a point, but internal medicine patients generally have multiple medical problems, they are on many medications and as the population ages, they are elderly. To see these patients effectively takes time. Medical practices have improved efficiency over the past ten years to survive, but now they have been squeezed to the limit. In the small town of Wilson, NC, we have seen 3 or 4 primary care physicians dismantle their offices and move in the past year because of this problem.

These issues directly impact access to care. You are probably aware of the trend to establish a practice that takes no insurance, Medicare or Medicaid. Most of these offices charge $25-$45 cash only per visit; by saving the insurance paperwork overhead, these practices have flourished locally. That is fine, but think about it: this model leaves out all of the most needy patients and the sickest patients. Believe me, right now, most doctors are cognizant of how little money they generate on a Medicare/Medicaid patient visit. They keep doing it because they are doctors. There will be a breaking point.

I see patients in a hospital setting and the increased RVUs and reimbursement for hospital visits and consultation is extremely important to us. Primary care medicine must remain a viable option, or you will see the number of young doctors in training opting for specialties and sub-specialties in the near future.

As a primary care physician, I urge you to finalize the recommended work RVU increases assigned to office, hospital visits, and consultative management.

Sincerely, Dawn Brezina
Durham Regional Hospital

Submitter : Dr. beth nalitt **Date:** 07/07/2006

Organization : american college of physicians

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I strongly support the increase in payments for E/M codes for internists. As a practicing internist in NJ, our practice costs have grown out of proportion to our income. In fact, our practice has lost 15% of gross income over the past 5 years due to rising costs of rent, malpractce insurance and payroll. Meanwhile, reimbursement for office visits has dropped and Medicare payments are a large part of our practice.

Submitter : **Dr. James Bowers** **Date: 07/07/2006**

Organization : **NW Primary Care, P.S.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

It's about time that FAIR reimbursement for ambulatory services be addressed. My overhead continues to go up and I can't continue to take less pay for more work. I live in Seattle and can't afford the median-priced home here!

Submitter : Dr. Robert Wright **Date:** 07/07/2006

Organization : Scranton-Temple residency Progra,

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I have run this primary care internal medicine residency since 1977. I started the Primary Care Institute at Temple U. Sch. of Med. in 1991. It is clear to me that reimbursement has driven physicians away from primary care. The proposed increease in RVU,s for evaluative servies is a strong step in the right direction.
Bob Wright

Submitter : **Dr. Carolyn Manhart** **Date: 07/07/2006**

Organization : **Creighton University Medical Center**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

To Whom It May Concern,
My name is Carolyn Manhart. I am an Assistant Professor of General Internal Medicine at Creighton University Medical Center. I want to encourage you to support the changes proposed to increase the work relative value units for primary care physicians. As a teacher in a medical school, I see how the numbers of students going into General Internal Medicine are decreasing rapidly. With the high cost of medical school and the wide disparity in pay between primary care and subspecialty services, students are choosing paths that will bring more financial rewards. In order to retain students in the needed fields of primary care, increases in reimbursement are necessary. Many students hear from practicing primary care physicians that they should choose a different field of practice because of poor reimbursement. The discontentment of many current physicians regarding their decrease in salary is obvious to students. The proposed changes in relative value units will help to relieve some of the burden resting upon primary care physicians to see more and more patients.
Thank you for your consideration of my comments.

Sincerely,
Carolyn Manhart, M.D.

Submitter : Dr. Victor Scott

Date: 07/07/2006

Organization : Howard University Health Sciences

Category : Health Care Provider/Association

Issue Areas/Comments

Other Issues

Other Issues

Academic Health Centers (AHCs) have a large medicare patient population, and depend on the generation of clinical revenue to contribute greatly to the financial support for the educational and research missions. The degree to which RVUs are downgraded negatively impacts the profit margins which support the AHC enterprise, and threatens the ability to train physicians at both the undergraduate and graduate levels.

Submitter : Dr. Joel S. Levine **Date:** 07/07/2006

Organization : Dr. Joel S. Levine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a gastroenterologist and perform both cognitive (E and M) services and procedures. I recognize that the consequence of this rule will reduce the amount I am paid for procedures, however, I want to strongly encourage the CMS not to change the recommended changes of the RUC. Currently I can earn 3x/hour doing a colonoscopy as in providing the consultation to decide whether a procedure is appropriate. This is wrong! The current payments provide no incentive for me to see and manage patients with chronic illness such as inflammatory bowel disease. This is wrong! The current system provides no financial incentive for me to maintain close communication with my patients 24/7/365. This is wrong!

Of course these inequities are magnified for primary care physicians, particularly general internists, who are being expected to carry the full burden of the quality initiative for the complex elderly patient. This is wrong!

In the face of pressure from other specialties I plead with you to stand fast.

Sincerely
Joel S. Levine, MD FACP AGAF

Submitter : Dr. Mary Anne Totten **Date:** 07/07/2006

Organization : Senior Health Primary Care, Manchester, NH

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am commenting on the Five Year Review of RVU's. I am a geriatrician and have been in practice for over 25 years. Over this time the complexity of problems for patients has steadily increased. Our patients on average have 5 problems at any given office visit. We have to schedule 30 min visits, because the customary 15-20 min visit cannot address all of the problems, and sort out issues of medication management, etc. I am also practicing in long term care facilities and skilled nursing facilities. Patients being discharged from hospitals have much more complex problems than they did 25 years ago. The rehab patient is not the simple hip replacement who needs OT and PT and then returns home. Patients may have severe peripheral vascular disease with gangrene, pain management, and management of diabetes. A recent patient had metastatic colon cancer with a ureteral stent and re-implantation of the ureter into the bladder. He developed sepsis and required re-hospitalization. He was very deconditioned and will require several weeks of therapy. Monitoring is necessary to prevent further septic episodes. The previous 15 min nursing home visit is now at least 30-45 min because of the complexity of the problems, and the time needed to care for the patient and his/her family. We need to attract more providers to geriatrics and primary care. Any notion of decreasing RVU's or reimbursement would discourage new physicians from entering these specialities. I encourage you to reject any notion of lowering the RVU's. Geriatricians need to be reimbursed adequately for the time and expertise that is needed for our senior population.

Submitter : Edward Hoffer

Date: 07/07/2006

Organization : Edward Hoffer

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I am a general Internist with a large number of elderly patients, and am at a stage where I can afford to retire, though I would like to keep working. As the costs of running a practice continue to rise much faster than does CMS reimbursement for seeing complex elderly patients, the decision to continue seeing Medicare patients has become problematic.

I can see a 30 year old with a sore throat in 5 minutes, and am reimbursed more for doing this than I am for seeing a 90 year old with eight active problems who "does not feel well" - which will take 20-30 minutes if done properly.

I would urge you to implement the proposed increases in RVU's for E&M services - this will help to assure continued access of Medicare benficiries to primary care services.

Submitter : **Dr. Jim Webster** **Date: 07/07/2006**

Organization : **Insitute of Medicine of Chicago**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments-
Evaluation and Management
Services

Discussion of Comments- Evaluation and Management Services

If you are going to have any primary care left in this country you must increase the E and M payments to make it possible for general interists and family practitioners to survive. As you must know they are crucial for maintaining continuity, chronic disese management and Quality. Thank you.

James Webster, MD, MS,MACP
President, Chicago Board of Health
Executive Director, Institute of
Medicine of Chicago

Submitter : Dr. Regina Gan-Carden **Date:** 07/07/2006

Organization : Franklin Square Hospital Center and MD ACP

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I (and every primary care physician and geriatrician) URGE CMS to finalize the recommended work RVU increases for evaluation and management services. Over the past ten years, the complexity and work associated with caring for complex patients, coordinating care, filling forms, prior authorizations, knowledge requirements to stay up to date, has increased dramatically, impacted negatively by the low RVUs. An increase in work RVUs will be a real but small step towards keeping physicians, and myself, in primary care, but of course, more needs to be done. At the least, it will help assure continued access to primary care and preventive services therefore preventing some of the outrageous costs of acute care medicine.
I urge CMS to reject any comnents that would lower the overall improvements in work RVUs for E/M services.

Submitter : Dr. Patricia Sadler **Date:** 07/07/2006

Organization : American College of Physicians

Category : Physician

Issue Areas/Comments

Other Issues

Other Issues

I urge CMS to finalize the recommended work RVU increases for E&M services. The coordination of care required now to care for increasingly complicated, sick patients at home and in assisted living facilities is extraordinarily time consuming and demands careful consideration of diagnoses and medications as well as ancillary services. Many of these services were provided in the hospital pre-"DRG" fifteen to twenty years ago.
Appropriate reimbursement for cognitive services will assure continued access to primary care services in the crucial baby boomer years to come. I beg CMS to reject any comments that would lower overall improvements in the work RVUs for E&M services.
Thank you.
Patricia Sadler, MD

Submitter : Dr. Ronald Ziman **Date:** 07/07/2006

Organization : Dr. Ronald Ziman

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

In California many of the insurers are now offering contracts at less than Medicare rates that are basically unaffordable to agree to. Despite that these are theoretically negotiated with the carrier, their attitude is basically take it or leave it. As a result I have dropped out of several insurance plans that unavoidably erodes public access to care.
Though I certainly want to avoid it, I have been forced to consider such action with Medicare as well. If nothing is done to correct the reimbursement disparity and my income and livlihood becomes further compromized, I will be forced to do the same with Medicare.

Practice Expense

Practice Expense

My expenses have done nothing but go up over the 29 years that I have been in practice. At the same time reimbursements have been basically flat or declined. When inflation in figured in my real income is down well over 40%. I am working much harder and earning less. As a result charity care and discounts have been basically curtailed. I have more people in less space to try to cut expenses.
Medicine is a major small business employer. Due to the fact that employees also have been cut to contol expenses, there is an unavoidable loss of jobs, reduction in efficiency of practice and erosion of quality of care.

Submitter : Dr. Bradley Bryan **Date:** 07/07/2006

Organization : Providence Health System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Without substantial reform in the payment system to Internal Medicine for intellectual services there will soon a primary care crisis. We have already seen this impact the primary care base in both the urban and rural communities. I would encourage the passage of the planned increases in RVU payments as one measure to be able to retain and recruit physicians in primary care internal medicine.

Submitter : Dr. Steven Yarows

Date: 07/07/2006

Organization : IHA

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I have been a practicing Internist for 25 years and I have never seen the current lack of internist in primary care. It is virtually impossible to recruit an American trained Internist into our practice. The major problem is reimbursement. As an Internist, my hours have become longer and my relative reimbursement adjusted for inflation is less. Yet, "invasive" physicians are being paid more and more for procedures that are commonplace. I do believe that many invasive physicans are overpaid (i.e.-dermatologist, anesthesiologist) I think that the proposed changes in the RVU's are important to allow American citizens proper healthcare.

Submitter : Dr. Charles Cutler

Date: 07/07/2006

Organization : Fornance Physician Group

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

The proposed RVU updates are essential to my practice which is 100% primary care. I have not been able to adequately upgrade equipment, and I have lost key nursing staff because of previous cuts in Medicare payments. The updated fee schedule would help reverse the trend of scaling back services for my Medicare patients.

The RVU updates are modest. If the proposed amounts are scaled back my ability to serve patients will be seriously jeopardized.

Please finalize the recommended work RVU increases for evaluation and management services.

Thank you.

Submitter : Dr. Brenda Burrough

Organization : Dr. Brenda Burrough

Category : Physician

Date: 07/07/2006

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

It is important that the evaluation and management services be rewarded for the process of diagnosing and managing patients. The effects of granting increased reimbursement for these serviced should increase the number of physician entering primary care specialties. The quality and patient satisfaction should increase as a result.

Submitter : Dr. Stephen Pauker

Date: 07/07/2006

Organization : Tufts-New England Medical Center

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I would likely to strongly endorse the RUC's re-evaluation of many of the common RVU assignments for evaluation and management (E&M) codes and other cognitive activities in medicine. Knowing CMS's budget constraints, it is clear that these suggested re-evaluations will not be popular among procedural specialties and will likely generate howls of discontent. As an internist and a cardiologist who works in academic medicine, I believe that the adjustments are not only right but are essential. In my own medical school I see a rapid decline in the number of students even considering careers in primary care. For the first time, even in a relatively physician rich state like Massachusetts, we have begun to see a crisis in the availability of primary care physicians. This crisis exists on both the input and output sides: few students are choosing primary care and established internists are bailing out. I saw my own brother-in-law, a triple-boarded internist, leave his long-standing primary care practice to become a less happy and less satisfied hospitalist, but one who is now financially stable. His former practice and our department's current primary care physicians manage extremely complex patients with multi-system disease. For physicians such as my bother-in-law and such as the primary care internists in our department of medicine at Tufts, E&M codes represent the bread and butter of their practice. But these codes have been so undervalued as to make primary care financially non-viable. Typical academic practices lose between $50,000 and $150,000 per FTE primary care physician, a clearly unsustainable circumstance.

I believe that these readjustments in assigned RVU values are long overdue and respectfully suggest that CMS maintain the increases in E&M work values recommended by the RUC in the proposed rule.

Stephen G. Pauker, MD, MACP
Associate Physician in Chief
Tufts-New England Medical Center
Professor of Medicine

Submitter : Dr. Michael Bronze

Date: 07/07/2006

Organization : OU Health Sciences Center

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I would like to offer my support to the CMS proposal to increase reimbursement for E/M codes. This will greatly strengthen access of Medicare patients to general internal medicine and subspecialty practices. I would be very concerned that without reform, Medicare patients will see a declining availability of physician services for their health care needs.

Submitter : Dr. JAMES GALLAGHER **Date:** 07/07/2006

Organization : GEISINGER CLINIC

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I WRITE TO URGE CMS TO FINALIZE RVU INCREASES FOR E/M SERVICES. These services grow more complex every year: in my practice we do PAIN as a "5th" vital sign for everyone inpatient or outpatient, Sexual histoory to evaluate for HIV/AIDS RISK ADDS MORE TIME. To do the job ETHICALLY and with ATTENTION TO DETAIL" takes time. Improvement in work RVUs is our only hope in prrimary care.

Submitter : **Dr. James Martin** **Date: 07/07/2006**

Organization : **Minor and James Medical, PLLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I urge implementation of the proposed increase in work RVU's for office and hospital E&M codes. Currently, I can spend over 50% of a visit coordinating care, and reviewing health maintencence issues with patients before ever getting to their medical problems. Increasing the RVU's will allow me to schedule more time with patients. Without these increases, it is likely that I will restrict my contact with medicare patients. Thank you.

Submitter : Dr. Judith Nerad

Date: 07/07/2006

Organization : Dr. Judith Nerad

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly urge you to please finalize the recommended work RVU increases for evaluation and management services. In my own primary practice of mostly HIV-infected patients the complexity and work associated with taking care of these patients during office or hospital visits and consultations has increased dramatically during the past ten years. HIV-infected patients are living longer on complicated medical regimens that have multiple side effects and drug reactions with other medications. These have to be managed as well. Additionally, as the HIV population ages, they have more medical issues besides HIV, including diabetes, heart disease, hypertension, renal disease, malignancies that are more aggressive than in the non-HIV population. Many of these diseases have to be addressed during the frequent office visits and are becoming increasingly reasons for hospital admissions if they are not controlled in the out-patient setting.

Changes in the reimbursement to providers will help assure continued access to primary care services because providers will be able to afford to see these patients.

Also, as I am sure you know, many providers in California, Nevada, Arizona, and other states have left their practices in those states because they cannot afford to practice medicine under such conditions of decreased reimbursement and high malpractice costs. In areas of the country where American citizens prefer to retire to, physicians are leaving or they are not accepting Medicare patients because they are not reimbursed enough for Medicare visits. How ironic for those of us or whose parents have paid into this system for so many years only to be humiliated by not being able to receive the medical care they need.

Additionally, primary care providers have gotten lower reimbursement rates for their visits than other providers. This has a deleterious effect on helping people maintain their good health or diagnose new problems because of time-limited visits. Cancers may go undetected for months, depression is overlooked, etc. Why is diagnosing these problems less valued than giving anesthesia? Think of your family members going to their primary care provider and coming home saying "they didn't have time to hear all my complaints".

I strongly encourage CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services. I is time that we start taking better care of our most vulnerable citizens.

Submitter : Dr. Jeffrey Crandall

Date: 07/07/2006

Organization : American College of Physicians

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I urge CMS to adopt the revision of the RVU payments for cognitive services provided by physicians. The disparity between those professionals who do procedures and those who try to prevent the need for procedures has been part of the historical environment which is so discouraging to those of us who have chosen primary care specialties in which to practice and must change to preserve the very future of those specialties.

It is well known that where there is a rich supply of proceduralists, cost of care increase. I can easily get frightened by considering a future where patients are bounced from one physician to another, each reimbursed for his/ her services only if something is done to the patient. It becomes a football game without a quarterback and I believe CMS can help prevent such a scary scenario from occurring.

You must begin to demonstrate honor for the services provided by primary care physicians by increases in reimbursements for their cognitive services. If you fail to do so, you will share responsibility for the dwindling numbers of young primary care physicians willing to accept the declining rewards for their services and hasten the retirement of their more seasoned colleagues.

Submitter : John Pixley **Date:** 07/07/2006

Organization : MedSchool Associates, North

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please finalize the recommended work RVU increases for evaluation and management services.
" The main problems with lack of compenstation continue to be incomplete and or inadequate records this is not compenstated
In addition office based reimbursement pale ins comparison to procedure oriented non office based services
A lack of recognition by reimbursement sources that patients do not have to be in the hospital to be sick and suffer.
I urge CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.

Submitter : **Dr. David Hallbert** **Date: 07/07/2006**

Organization : **David Hallbert, MD**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I practice internal medicine in a rural area. The amount of necessary work that goes into a coded visit has risen dramatically. Patients are older and have multiple problems with can now be treated with more complex therapies. Our therapies have to be monitored objectively and reimbursement is dependant on meeting quality measures. The value of prevention is much greater than it ever was as more expensive therapies are available for emergency care. I hope you will consider that INternists now have to invest in electronic medical records to be able to deliver more and more routine care, more office staff is needed to track, monitor, and treat, and their value as educated knowledge worker's expands the employee budget. Please recognize the increased value of E and M coding. Doing so will ensure practicing MD's continued willingness to practice quality medicine, contain higher expense futile care and improve access by patients to care in primary care offices.

Submitter : Dr. Mark Mayer **Date:** 07/07/2006

Organization : Amer. College of Physicians (OH Governor-Elect)

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

The primary care workforce (including general internal medicine) is at threat of collapse. Fewer medical students and residents are choosing to go into primary care fields over the past 8 years (reprising a similar decline from 1982 to 1992, but falling more precipitously this time around). There is also a higher rate of physicians leaving general internal medicine early than for other specialties. It is important to reverse this, as we have a growing need for well-trained primary care physicians, with an aging, more medically complex population. The undervaluing of evaluation and management services, particularly those given by Internists to patients with complex, chronic illnesses is an important reason for the declining interest in primary care. The RUC came out recently with a recommendation to increase work RVUs of key Evaluation and Management services that are crucial to primary care physicians by about 30%. CMS supported these recommendations in its recently released propsed rule.

It is vital to uphold these proposed increases. I can attest to the increased complexity of work in caring for patients with multiple chronic illnesses since inception of the RBRVS over 14 years ago. The pre-work, post-work, and face-to-face work with patients is clearly much greater, and reimbursement for this has fallen behind. For example, when I started practice 21 years ago, caring for a diabetic was much easier. Monitoring recommendations were few, most diabetics didn't have home glucose monitors, blood pressure recommendations weren't as stringent, the first statin had just come out, and diabetics weren't specifically targeted for their use. The average diabetic patient I care for now is on about three times more medications, I have about triple the monitoring requirements, glucose and blood pressure diaries are now a regular feature of in-office or between-visit discussions - and most diabetics have a number of other illnesses I'm co-managing. Reimbursment for E and M services rendered to patients with chronic illnesses such as this must go up, or the supply of well-trained physicians to care for these patients will shrink such that their care is further compromised. The cost to the public will go up, as more complications arise, and better-reimbursed services (e.g. cardiac procedures, laser retinal treatments, vascular procedures, amputations, dialysis) are provided at greater volume to care for the complications that inevitably will ensue.

Mark Mayer, MD, FACP
Governor-Elect
Ohio Chapter of American College of Physicians

Submitter : Dr. Christopher T. Parker **Date:** 07/07/2006

Organization : Austin Diagnostic Clinic

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

This is important: please consider.

Submitter : Dr. Emily Hitchcock

Date: 07/07/2006

Organization : Dr. Emily Hitchcock

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a primary care provider and internal medicine faculty member I think it is critical to the future of primary care that the reimbursement is more commensurate with our colleages in procedure based subspecialties.

Submitter : Dr. David Sandvik **Date:** 07/07/2006

Organization : Internal Medicine and Geriatrics Associates

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

As an office-based internal medicine physician for over 25 years with a specialty in geriatrics, who continues to practice geriatrics in nursing homes and the hospital, I whole-heartedly support the increases in reimbursement for the evaluation and management (E&M) codes for medical practice. Studies have shown that these codes have fallen behind codes for procedures ever since the Relative Value Scale was introduced as the basis for physician reimbursement. The reasons involve continued introduction of new procedures which are valued at a higher level than previous procedures because they are new. Then as these procedures become old, their relative values are not decreased, though now they have become common.

The net effect of poor reimbusement for E&M codes is devestating to the US healthcare system. Medical students do not choose primary care careers because reimbursement in that field is tied to E&M work. In Rapid City, SD, my home town, office-based internists have been leaving the office practice to become hospitalists for the fewer hours and more stable income that field provides. It is very difficult to find an internist as a personal physician here now. Internist provide ongoing care for the most complex and vulnerable patients. Without office-based internists, care of our frailest patients will suffer.

So, primary care physicians are leaving that field and new physicians are not choosing primary care. The net effect is that the United States cannot produce the level of excellence in basic medical care that many other countries provide with less cost and less sophisticated medical systems, countries such as Cuba. Without readjustment, the overall quality of care in this country will continue to decline. If patients become sick, they will have plenty emergency physicians, anesthesiologists, and specialists to provide for them until they return to baseline. However, to find physicians who control blood pressure, diabetes, and high cholesterol; make sure cancer screening occurs; treat Alzheimer's Disease; and insure cost-efficient, compassionate care is given at end of life is difficult now and will become more difficult in the future. Essentially, finding a "personal" physician will become a challenge.

For these reasons we need incentives for physicians to be evaluators and managers rather than proceduralists, to think before doing. Studies have shown that 88% of diagnoses are made at the end of a brief history and some subroutine of the physical examination in primary care visits. In general medicine clinics (with more complex patients) 56% of diagnoses are made by the end of a good history of the illness, with 73% of diagnoses made by adding a physical exam. Only another 10-15% of diagnoses are made with further diagnostic testing. So, the conclusion is that the history and physical exam is the most cost-effective procedure in medicine: all evaluation and management. However, with poor reimbursement, the history and physical is likely to be rushed and physicians jump to costly diagnostic tests that are likely less accurate than taking the time to listen to the patient, do a physical examination and think long enough to make the correct diagnosis and prescribe the correct treatment. The E&M codes are the best value in medicine for providing quality care. They need to be updated to be effective.

Physicians have lost faith in evaluation and management because of lack of value placed in the process by the system. That faith needs to be restored by placing reimbursement where the value for the system actually is.
David Sandvik, MD, FACP, CMD

Submitter : Dr. sam miller

Date: 07/08/2006

Organization : Dr. sam miller

Category : Physician

Issue Areas/Comments

Background

Background

Please pass the proposed RVU increases. Our costs for practicing medicine and serving patients keep increasing and more and more doctors are forced to close our doors.

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

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

For most pathology clinical lab tests, the cost to perform the test is more than is reimbursed. Equipment and reagent vendors have been raising--not lowering--their charges. Soon, patients will not be able to receive these tests because we cannot perform them due to financial losses. Please increase the physician reimbursement for lab tests. Thanks.

Practice Expense

Practice Expense

Costs of running an internal medicine and endocrinology practice are increasing: rent, personnel, equipment. Please increase cognitive services fees to accomodate physician overhead price increases.

Submitter : Dr. Warren Evins

Date: 07/08/2006

Organization : Dr. Warren Evins

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I support the increase in valuation of the E & M Services codes.

Thank you.

Warren Evins, MD

Submitter : **Dr. James Corsones** **Date: 07/08/2006**

Organization : **Kingston Internal Medicine Associates**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

I have been a primary care provider for twenty four years. in that time, my patient population has aged and developed more frequrnt and complex medical problems. It is increasing difficult to adequately address all their issues in the limited time available in order to run a cost efficient office. E/M services have been undervalued for many years. It is sad that I am reimbursed more for taking off a small skin lesion than reviewing and adjusting medications for patients with multiple medical problems. Many of them suffer from diabetes, hypertension and elevated lipids- all of which have to be addressed in a 15 minute office visit. With the advent of procedure based medicine and the prospect of pay for performance, documentation and addressing all these issues becomes more difficult. Additionally, expenses-especially in New York where the insurance administration has okayed a double digit increase in malpractice premiums- continue to rise while we struggle every year with Congress threatening to reduce reimbursements for physicians. This review of relative value units will improve the situation greatly and help ease some of the burden on primary care practices. It should also improve our abilitiy to afford electonic medical records. EMR should greatly improve efficiency and quality of care. I wholeheartedly support this proposal and encourage you to pursue a more equitable course so that we can spend more time providing care and less time dealing with the administration of health care. Thank you.

Sincerely,

James Corsones, M.D.

Submitter : Dr. Michael Butcher

Date: 07/08/2006

Organization : Dr. Michael Butcher

Category : Physician

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

It is my understanding that there is consideration to increase the value of evaluation and management RVU's. This is an extremely important update that is sorely needed at this time. Currently, Primary Care Internal Medicine is the number one search for new physicians. This is during a time when many residency programs are phasing or considering phasing out the Primary Care aspect of their Internal Medicine training programs. The reason for doing so is readily apparent in that the demand for these positions has diminished drastically. The reason for the decrease interest in the Primary Care positions is that the work load in our practice has been horribly increased, due to paper reviews. These reviews are extremely burdensome and costly in time and personnel. Also the incomes from subspecialty care is dramatically higher than for primary care. It is easy to figure that new physicians will want to go into a specialty with lower work load and hassle factors while making a higher income. This is also at a time when the population of the U.S. is going to be aging and we will need many more Primary Care physicians.

I chose Primary Care because that is what I enjoyed, but recently have been recommending to young people entering medical school to seriously consider one of the specialties with better life style and incomes. Hindsight now tells me that I could enjoy other areas of practice with greater income and less hassle and I can't be honest with these young people and encourage them to do what I do.

Physicians in subspecialty care and surgical specialties will rarely take on the regulatory burden of paper work required to obtain patients medication, durable medical equipment, and assist devices. As a result it falls back to the primary care physician to do it or the patients will not recieve the needed equipment they need. While there has been some increase in reimbursment for these services they are inadequate to compensate a physician for the time spent trying to accomadate the needs of the payors who are evaluating the need for such services. Consequently patients may do without or the paper work is done by the primary care physician without careful review of the true need. It is common for me to recieve 20 faxes a day from homehealth agencies, durable medical equipment providers, and hospices. This is in addition to phone calls and office visits. Most of the burdensome paper work is a direct extension of providing primary care.

The current reimbursement for evaluation and management is abysmal. I can make more for removing a skin tag (11200-$63.42) that requires no brain work, can be done in less than 3 minutes and that I teach my pts. how to do it themselves in less than one minute than I get for an 'expanded visit' (99213-$48.16) that requires evaluation of a low or moderate problem and is expected to take 15 minutes. I also can get more for a simple suturing of the smallest laceration (12001-$131.00) than I can for a 'comprehensive exam' (99215-$110.96) that involves moderate to high severity and is expected to take at least 40 minutes. A simple appendectomy (44950-$537.38)pays 3 times and a total knee replacement (27447-$1,341.58) pays almost 10 times what a comprehensive new pt. workup for an inpatient (99223-$148.53)that may be in cardiogenic shock, new heart attack, stroke, or severe G.I. hemorrhage. I am not claiming that a 99223 should be reimbursed more than the Appy or Total knee, but the differential in the complexity of the problem, the stability of the patient, and the risk of death in comparison to the reimbursement is enormous and absurd. This update is long over due. Without some adjustment the elderly of the future will be horribly underserved with Primary Care.
In my practice of 9 Internists, I am the only one who will accept new Medicare pts. without restriction. That is a shame.

Submitter : Dr. Daniel Elliott

Organization : Dr. Daniel Elliott

Category : Physician

Date: 07/08/2006

Issue Areas/Comments

GENERAL

GENERAL

I have been anticipating this recommendation for some time. As a young physician who received a primary care scholarship through medical school, I am committed to primary care medicine. I have been saddened as quality colleagues interested in primary care choose other options simply because of the financial reality of student debt and the relatively paltry reimbursement combined with the grueling work done by internists and family practitioners in the community. I think the increase in valuation of E/M codes is an initial, necessary step in changing my colleagues' attitudes towards primary care and non-procedurally based specialties and recognizes the vital role these physicians play in the lives of the majority of Americans. I hope more can be done before our aging Boomers awake to find no doctor to care for them.