Submitter : Dr. Joan-Alice Taylor **Date:** 08/11/2006

Organization : Taylor Therapy Center, P.C.

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-1254-Attach-1.DOC

Attachment ##
1254

Taylor Therapy Center

9 Elmwood Court• Newington, CT 06111 • (860) 953-1204

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Attention: CMS – 1512-PN

Dear Dr. McClellen,

I am a physical therapist in private practice and my practice is a Rehabilitation Agency under Medicare. I have been in practice for over 35 years and in private practice for 25 years. I am writing to comment on the June 29th notice regarding the proposed revisions to work relative value units, and revises the methodology for calculating practice expense RVU's under the Medicare physician fee schedule.

I urge CMS to assure that the severe Medicare payment cuts for physical therapists and other health professionals do not take place in 2007. Transitioning the changes to the work RVU's over a four-year period would ensure that patients would continue to have access to valuable health care services. The current "Sustainable Growth Rate" (SGR) formula is projected to trigger a 4.6% cut in payments in 2007. The 5-year review rule places further cuts added to the SGR making the cuts for physical therapists closer to 10% in 2007. This is completely unreasonable to have policies that place cuts on cuts.

I understand that CMS is emphasizing the importance of increasing the evaluation and management work values by 37% and support an increase in this area. It is appropriate to encourage physicians to manage illnesses more effectively and have better outcomes. However, physical therapists cannot bill under these codes and derive no increase in payments for the examinations and evaluations that we provide to patients. The value of all services to patients by Medicare providers should be acknowledged under this payment policy. Physical therapists and other non-physician providers offer extremely valuable services to patients beyond medicine and surgery. These services rehabilitate the patients and restore them to functional levels so that they again become valuable and participating members of society.

In my practice, located in a community where more than one-third of the population is over 65 years of age, a large portion of our patients are seniors. Since the fee schedule was implemented with the time altered from the CPT existing coding system of 15-minute intervals, or part thereof, payment for services in my practice have been ranging from $50.00 to $75.00 per patient visit. A visit in this office is an hour to an hour and a

half because of the type of patient problems we see. (We rarely have a patient with "tennis elbow" who would be a thirty to forty-five minute visit.) We see many people with gait and balance problems, joint replacements, post-surgical rotator cuff repairs, severe osteoarthritis, post-CVA's, spinal stenosis, post-fractures, etc. etc. Our patients are one-on-one treatment for forty-five minutes or more. Since we can bill for only the one-on-one treatment time there is a lot of exercise time (it is not "group," and may be supervised by the PT aide) that is not billed nor is the charting or report time billable causing the practice to absorb the costs of non-billable time. In addition, there is time that is communication time or counseling time with the patient that is necessary and also is not billable.

Now, the real challenge are the costs of doing business. It costs this practice $110.00 to $120.00 to provide a treatment to a patient per day! How do we do it? We work nine to ten hours a day, have therapists on salary, have staff doing more than one job, see as many patients as we can possibly fit into the schedule every day, and do not buy new equipment, or make a profit. Our costs will increase significantly this year because of the increase in utilities in Connecticut, but we will not know how much until the end of the year. Any other business would quit and close because it is not good business sense to remain open!

We may have to decrease the number of Medicare patients we can see in order to remain open and continue to practice at all. The payment should at the very least equal the costs of providing the services, which it does not. Additionally, inflation does not cease because CMS calculates reduction in payments, so the end result will be few to no providers, or limits on the number of Medicare patients that can be seen.

I urge you to rethink these decreases in the work and practice expense values that are significantly reducing the payments for services by physical therapists and other health care providers. Again, I urge you to make the transition extend over a longer time period, four years, and not placing cuts on top of cuts.

Thank you for your consideration of my comments. I hope I have offered some clear examples of why these reductions in payment would severely hamper the services to Medicare recipients.

Sincerely,

Joan-Alice Taylor, Psy.D., P.T., L.P.C., F.A.B.D.A., C.B.T.

Submitter : Helen Schuster **Date:** 08/11/2006

Organization : Mental Health Management Services

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

A 14 percent reimbursement cut would affect my practice as a Medicare provider in that the adjusted reimbursement would not cover the office expenses required to provide services to Medicare recipients and, regrettably, may require my limiting availability to this population. I am one of a very few psychotherapists in the Miami area who is well trained in cognitive behavioral therapy and who specializes in the treatment of the anxiety disorders and depression. For instance, I am working at the present time to get a young woman with Panic Disorder, who is on Medicare disability. back into the work force. My services actually save Medicare money even at the current reimbursement because the services I provide are effective within a very short period of time and address such disabilities as well as addressing unnecessary visits to physicians and ER s that are related to anxiety and depression.

Please do not reduce work values by 7 % for clinical social workers.

Please withdraw the proposed increase in evaluation and management codes until there are funds to increase reimbursement for all Medicare providers; and please do not approve the proposed Top down formula to calculate practice expense instead select a formula that does not create a negative impact for mental health providers.

Thank you for your time and consideration in this matter
Helen E. Schuster, LCSW

Submitter : Mrs. Virginia Morgan **Date:** 08/11/2006

Organization : W and W Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

I am greatly concerned about proposed cuts for physical therapy starting next year. Our clinic is 1/2 hour north of Tucson and services large retirement communities and a few small rural mining communities. We have 75% of our patients under medicare coverage. This fee drop would cause us to go out of business. Our patients could not get coverage in a reasonable distance from their home if we close. Many travel 1/2 hour now and some up to 1 hour to get to the nearest clinic for service and if we close would have to travel another 1/2 hour in dense traffic.

I am aware of the need to cut costs but therapy is necessary for our elderly to live productive lives. For most therapy is not an option but necessary.

I have seen abuse of medicare but it is not in my area of out patient therapy. Where I have seen abuse is in the acute care of seriously ill patients who are kept alive unnecessarily when there is no potential to get better and in the use of major surgeries for those who have little potential to return to a functional life.

Therapy reaches to those who are trying to live independently and addresses health issues in their life. Many are volunteers in the community and all are contributing to society in some way.

It is urgent that these proposed cuts in medicare not be implimented in the area of physical therapy.

Submitter : **Ms. Beth Sarfaty** **Date: 08/11/2006**

Organization : **Kessler Rehabilitation Center**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

My name is Beth Sarfaty and I am a PT with Kessler Rehabilitation Center. I am the VP of Clinical Services and have had this position for 6 years and have been a practicing PT, primarily in OP Orthopedics for 17 years.
I would like to comment on the June 29 proposed notice that sets forth the proposed revisions to work relative value units and revises the methodology for calculating the practice expense RUVs under the Medicare fee schedule.
Please do NOT allow these severe cuts to PTs to occur in 2007.
I recommend to transition the change over a four year period so patients can have access to the healthcare services they so desperately need and deserve the right to have.
Since PT's can bill the E/M codes, 2007 will be a devasting year for us and once again, the Medicare beneficiaries that require the services, will be the one's to suffer the impact.

Thank you for the consideration of these comments.
Sincerely,
Beth Sarfaty

Submitter : Dr. Richard Young **Date:** 08/11/2006

Organization : Dr. Richard Young

Category : Physician

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

The proposed increase in RVUs for E/M services is long overdue. Thank you for addressing this historical inequity. However, there is still exists an institutionalized disregard for the work that family physicians actually perform.

According to the 1997 E/M guidelines a patient with two or more chronic stable illnesses can be billed as a 99204 or 99214, which realistically is the upper limit code a family physician can commonly bill. The 99205/99215 outpatient code is a joke. Every example in the CPT book for what kind of presenting problems qualify to be a 99205/99215 describe patients that should be admitted to a hospital. If the family physician sees the patient who presents with one of these presenting problems, he must record an H&P at his clinic, then he must perform another at the admitting hospital, assuming that he will maintain continuity care by caring for his patient in the hospital. Of course, Medicare and other payers will only pay the family physician for one E/M visit, even though the physician had to perform work at 2 separate sites. This is another historic inequity that must be addressed.

Back to the 99204/99214 codes, the fact of the matter is that the average visit to a family physician involves THREE problems that are addressed (Beasley JW, et al. Ann Fam Med 2004;2:405-410.) Therefore, if a family physician addresses three chronic diseases at one visit, his work on the third disease was not paid for. The family physician was forced to give away his expertise, time, malpractice exposure, and service. Similar examples include visits that deal with one chronic disease and one acute problem, and visits with 2 acute problems. Remember, three problems is the AVERAGE. A significant minority of our visits involve patients with 4 or more chronic diseases, typically with other acute problems on top of that.

Another absurdity in the current rules is the declaration that counseling greater than 50% of the visit should be billed by time, but less than that be billed under the standard problem-based approach. I am not suggesting that we should be paid for brief education about tendonitis, if that was our new diagnosis for a patient's elbow pain. However, many of our visits involve more than brief counseling and education.

For these instances we should be paid at the first minute of service, not the last. The prolonged visit codes are also a joke. Many of our extended counseling/education sessions are in the range of 5-10 minutes beyond a smooth patient visit. The 30 minute minimum requirement for extended visits in the CPT codes is absurd. Lawyers are allowed to charge for the first minute, so should we. (A lawyer can bill for 10% of the billable unit; in this case 1 hour. If she spends 7 minutes on an account, she can bill for 2 10% units, or 12 minutes). I would argue that our work unit is about 20 minutes. Therefore, we should be able to bill excessive time issues in 2 minute increments.

The fact that the current E/M rules do not allow family physicians to express the work they do indicates that the methodology for determining these work units is fundamentally flawed. There needs to be a new approach for billing generalist care that is additive. If I deal with one chronic condition only, I should bill for one chronic condition. If I deal with 3 chronic diseases, 2 acute problems, and 2 preventive interventions, I should be able to submit a bill with 7 items -- and each of them paid in an additive fashion.

Until an approach like this is taken, generalist care will continue to be under-paid and under-appreciated, because generalists will be systematically barred from coding and billing the complex work they provide. Medical students will continue to be uninterested in primary care and the overspecialization of American health care will continue, continuing our history of overly costly, poor quality health care.

Thank you for your time and attention to this matter.

Submitter : Mr. Bruce Cotti **Date:** 08/11/2006

Organization : Florida Diagnostic IMAGING, INC

Category : Health Care Industry

Issue Areas/Comments

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

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

This is in regard to the proposed reduction in reimbursement of the CPT 76075 (DXA). As a small independent facility the proposed change would mean that I could no longer provide DXA studies there by increasing patients risks of costly repair of future fractures. The cost of the equipment and maintenance would have to drastically change along with all related insurances ie: malpractice. You have to understand ANY decreases effect all our HMO agreements (thanks to our government) which in today s world is 85-98% of our referrals base. If you want to save, make the self referral law apply to groups of doctors as it applies to independents. Being in this line of work for @30 yrs. I see more and more exams that would most likely not be ordered if the physician groups were no longer allowed to self refer and own their own high end diagnostic equipment. I feel you would save millions not thousands!!!!

Bruce Cotti R.T.(R)A.R.R.T.
Owner of Florida Diagnostic Imaging, Inc

Submitter : Mr. Patrick Albert **Date:** 08/11/2006

Organization : Whiteside County Community Health Clinic

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

The proposed downward adjustment of work values and practice expense values is unjustified. It will reduce the number of service providers available to meet the needs of poor, uninsured and underinsured men, women and children who are often at the greatest need of Social Work services. It would be far better to make other adjustments in the co-pay required.

Submitter : **Ms. Phyllis Geller** **Date: 08/11/2006**

Organization : **Self-employed**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am writing about CMS-1512-PN.
Licensed clinical Social Workers provide a valuable service to their communities. Any decrease in fees paid by Medicare negatively affect our ability to pay our always rising expenses.
I am requesting that the 7% reduction be withdrawn. I am also requesting that you withdraw the proposed increase in evaluation of management codes until funds are available to increase reinmbursement for all Medicare providers.
Please reject the proposed 'Top Dog' formula to calculate practice expenses and select a formula that does not create a negative impact on mental health providers.
Sincrely,
Phyllis L. Geller, LCSW, DCSW

Submitter : Ms. Shirley Miller **Date:** 08/11/2006

Organization : Samaritan Health Services Lincoln City, Oregon

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

This proposal to change the reimbursment for Bone Mineral Density Testing of our elderly is absurd. The DEXA exam is one of the best tools for determining fracture hazzard and potential, and to get early detection so prevenative measures can be taken. By removing this tool, you are in virtually placing countless medicare patients in serious harm. If the point is to save taxpayer dollars then you are going about this wrong. The cost to transport, repair, and rehabilitate a fracture is by far a greater expense than a prevenative measure and prevenative treatment. You must stop and review this proposed change. In our interest to save dollars we are infact causing another problem.

Submitter : **Dr. neil fruman** **Date: 08/11/2006**

Organization : **jmmg**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the proposed rule to increase the work relative value units assigned to Medicare Evaluation and Management codes, as recently proposed by the Centers for Medicare and Medicaid Services (CMS). As you know, family physicians provide essential services to many Medicare beneficiaries and the costs related to providing these services have increased significantly in the last 10 years. As a result, we have had to see a greater and greater number of patients per day, simply to keep our doors open, while many of us have seen our incomes decline as payments have not kept pace with the cost of providing services. Further, the care of our patients has become increasingly complex, as family physicians are often managing patients with multiple chronic diseases with co-morbidities, acting as care coordinators, and dedicating more time to helping our patients and their families.

I am pleased that CMS understands the importance of improving payment, both to recognize the substantial increase in costs and time that most family medicine practices are experiencing, and to help lessen the gap in payment between primary care and other specialties. Further, this payment increase is an important first step in addressing the looming shortfall in access to primary care services that is projected, as fewer physicians choose family medicine and other primary care specialties.

The numbers of FP residences and graduates is decling annually. The cost of living and cost of practicing is rising steadily. If fees and reimibursment do not keep pace, the end of our Healthcare system is in site. Neil Fruman MD 8/11/06

Submitter : **Miss. Gayle Thomas** **Date: 08/11/2006**

Organization : **Tates Creek Family Practice**

Category : **Other Health Care Professional**

Issue Areas/Comments

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

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

We believe that cuts in the DXA reimubursement as proposed, will negatively impact women's access to this important test.

Submitter : **Dr. Allan Halbert** **Date: 08/11/2006**

Organization : **Tates Creek Family Practice**

Category : **Physician**

Issue Areas/Comments

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

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

If proposed changes to DXA reimburements are adopted, I believe this will have a significant impact on patient access to osetoporosis screening.

Submitter : **Dr. Edward Standiford** **Date: 08/11/2006**

Organization : **Tates Creek Family Practice**

Category : **Physician**

Issue Areas/Comments

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

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

If proposed changes to DXA reimburements are adopted, I believe this will have a significant impact on patient access to osetoporosis screening.

Submitter : **Mr. charles allen** **Date: 08/11/2006**

Organization : **Mr. charles allen**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

A 14 percent reimbursement cut will negatively affect my practice and myself as a Medicare provider. Please do not reduce work values by 7 % for clinical social workers effective January 1, 2007. Please withdraw the proposed increase in evaluation and management codes until funds to increase reimbursement for all Medicare providers are available. Please do not approve the proposed Top down formula to calculate practice expense. Please select a formula that does not create a negative impact for mental health providers.

Submitter : Dr. Timothy Scott **Date:** 08/11/2006

Organization : Tates Creek Family Practice

Category : Physician

Issue Areas/Comments

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

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

If proposed changes to DXA reimburements are adopted, I believe this will have a significant impact on patient access to osetoporosis screening.

Submitter : Dr. Beth Holmes **Date:** 08/11/2006

Organization : Tates Creek Family Practice

Category : Physician

Issue Areas/Comments

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

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

If proposed changes to DXA reimburements are adopted, I believe this will have a significant impact on patient access to osetoporosis screening.

Submitter : **Dr. Edgar Emeric** **Date: 08/11/2006**

Organization : **Tates Creek Family Practice**

Category : **Physician**

Issue Areas/Comments

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

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

If proposed changes to DXA reimburements are adopted, I believe this will have a significant impact on patient access to osetoporosis screening.

Submitter : **Mrs. Tonya Coburn** **Date: 08/11/2006**

Organization : **Tates Creek Family Practice**

Category : **Physician Assistant**

Issue Areas/Comments

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

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

If proposed changes to DXA reimburements are adopted, I believe this will have a significant impact on patient access to osetoporosis screening.

Submitter : **Date: 08/11/2006**

Organization :

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am responding to the proposed notice on the Physician Fee Schedule dated June 29, 2006. A 14 percent reimbursement cut will dramatically affect practice for all clinical social workers who are Medicare providers. This proposed cut is, at best, irresponsible. This will leave patients without services and treatment.

I urge CMS not to reduce work values for clinical social workers effective January 1, 2007. I ask CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and not to approve the proposed "bottom up" formula to calculate practice expense. As a clincial social worker, I am demanding that CMS select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Submitter : Dr. Cecil Huang **Date:** 08/11/2006

Organization : Loudoun Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increase for a handful of specialties. The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses. CMS should gather new overhead expense data to replace the decade-old data currently being used. CMS must address the issue of anesthesia work undervaluation or our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine.

Submitter : Dr. Jeffrey Schouten **Date:** 08/11/2006

Organization : American Academy of HIV Medicine

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachement

CMS-1512-PN-1274-Attach-1.DOC

Attachment H
1271

AAHIVM
AMERICAN ACADEMY OF HIV MEDICINE

1705 DeSales Street NW, Suite 700
Washington, DC 20036
Toll-Free: 866.241.9601
T: 202.659.0699 F: 202.659.0976
www.aahivm.org

August 10, 2006

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

Re: CMS Proposed Changes Relative Value Units

The American Academy of HIV Medicine is an independent organization of HIV Specialists and others dedicated to promoting excellence for all patients in HIV/AIDS care. We are the largest independent organization of HIV frontline providers, with 2,000 members providing direct care to more than 340,000 HIV patients—more than two thirds of the patients in active treatment for HIV disease. We are pleased to offer the following comments on the Centers for Medicare and Medicaid Services' proposed increases to select work relative value units (RVUs), which determine rates of reimbursement for physicians providing medical care.

The AAHIVM strongly endorses the proposed upward revision of RVUs. Today, a steadily declining number of physicians are choosing HIV medicine as a specialty, while the number of patients continues to grow (1). This imbalance, with its dangerous implications for patient access to care, stems from the discrepancy between the extremely specialized work and the infamously minimal rates of reimbursement that characterize HIV medicine; we believe that increased RVUs are the first step to ameliorating this imbalance.

Physician compensation continues to represent a dire hindrance in the domestic battle against HIV/AIDS. Doctors simply are not making enough money to keep their practices afloat. Less than 2% of total HIV Medicare payments, or only $360/patient annually, goes towards paying healthcare providers (2). In part, compensation is so low because HIV-infected individuals rarely need the major procedures for which doctors receive more generous rates of reimbursement; instead, the mainstays of HIV care are regular monitoring of patient status and prescription adjustment. These services are all part of the evaluation and management category most positively affected by the proposed RVU changes.

Although these services receive low compensation, they add up to one of the most challenging medical specialties. Over the past decade, the available antiretroviral (ARV) therapies and opportunistic infection prophylaxis treatments for HIV/AIDS have multiplied in number and transformed in nature. Among the complexities currently inherent to HIV medicine are:

- multi-drug antiretroviral regimens which require comprehensive knowledge of drug interactions, including the frequent introduction of new therapies;
- management of toxic, often long-term drug side effects;
- evaluation and treatment of HIV drug resistance;
- management and treatment of co-infections such as hepatitis B, hepatitis C, and TB, or other complicating factors like pregnancy and substance abuse
- management of depression and other mental disorders.

Social factors exacerbate the complexity of medical care. HIV patients are more likely to be or to become economically disadvantaged, socially stigmatized, mentally disabled, and homeless, all of which make administering consistent, effective, and funded HIV care more difficult.

The HIV medical provider workforce is close to crisis in its capacity to care for the HIV-infected population. Providers are leaving the field and fewer new providers are replacing them. Low reimbursements, greater demands on those providers receiving federal funds, and better opportunities in other disciplines, all combine to make HIV medicine an increasingly unpopular field. Making the situation potentially more dire, the Center for Disease Control's efforts to expand HIV testing as part of routine care will likely identify another 250,000-320,000 HIV-infected individuals, adding to the disproportion of those in need of specialized care and the diminishing pool of expert medical care providers.

With fully half of HIV-infected patients on Medicare and/or Medicaid, these revised guidelines will have a direct and substantial impact on HIV specialists. Higher RVUs for clinical visits will more accurately reflect the degree of work, determination, and education that physicians put into patient care, and consequently do much to alleviate the shortage of doctors in HIV medicine while allowing current specialists to more adequately protect the health and well-being of our broad, dependent patient population.

We therefore urge you, in the strongest possible terms, to increase the relative value of evaluation and maintenance services within Medicare. Please contact our Director of Public Policy, Greg Smiley, with any additional questions or comments.

Sincerely,

John Stansell, M.D.
Outgoing Board Chair

Jeff Schouten, M.D.
Incoming Board Chair

1. Saag M. Ryan White Care Act Reauthorization: we need help. Topics in HIV Medicine, IAS-USA;14:93-4, 2006.
2. Cubanski J, Neuman T, Kates J , Carbaugh A, Han E. The role of Part D for people with HIV/AIDS:coveragne and cost of antiretrovirals under Medicare Drug Plans. Kaiser Family Foundation, July 2006; Presented: President's Advisory Council on HIV/AIDS, 2006.

Submitter : **Ms. Pat Gallagher** **Date: 08/11/2006**

Organization : **Ms. Pat Gallagher**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1512-PN A decrease in reimbursement rates to social workers would have a serious impact on my practice and would most likely lead me to stop accepting Medicare patients. The current fee is already considerably less than my regular reimbursement rate. If it is even lower I simply will not be able to afford to accept Medicare patients any longer. Sincerely, Pat Gallagher, LCSW

Submitter : **Mr. Rob Sarbach** **Date: 08/11/2006**

Organization : **Shannon Medical Center**

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

Please see attachment for comments

CMS-1512-PN-1276-Attach-1.DOC

Attachment
#1276

August 11, 2006

To: Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

From: Rob Sarbach, PT
Director of Rehabilitation & Fitness Services
Shannon Medical Center
120 E. Harris
San Angelo, TX 76902

Attention: CMS-1512-PN

Dr. McClellan,

My name is Rob Sarbach, and I'm a physical therapist practicing in San Angelo, TX. I'm writing you to address my concerns regarding the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule.

I recognize the importance of increasing payment for E/M services to allow physicians to manage illnesses more effectively and therefore result in better outcomes. Increasing payment for E/M services is important – but the value of services provided by all Medicare providers should be acknowledged under this payment policy. Physical therapists spend a considerable amount of time in face-to-face consultation and treatment with patients, yet their services are being reduced in value.

I urge you to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007. Since such severe cuts would jeopardize access to care for millions of the elderly and disabled.

Thank you for your consideration of my comments,

Sincerely,

Rob Sarbach, PT
Director of Rehabilitation & Fitness Services
Shannon Medical Center
120 E. Harris
San Angelo, TX 76902
(325) 659-7413

Submitter : Kathleen Buescher **Date:** 08/11/2006

Organization : Provident, Inc.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Provident is a provider of outpatient mental health services reimbursed by Medicare, other insurance programs and private payment. We know that depression is a leading cause of mental health problems for older adults, often leading to suicide. Our mental health treatment of Medicare recipients is an essential resource in the community. A 14 percent reimbursement cut will affect our ability to provide services. Already we are subsidizing the care since Medicare payments do not cover our costs. Reducing reimbursement only exacerbates this problem. I request that CMS not reduce work values by 7 % for clinical social workers proposed for January 1, 2007.

Submitter : Dr. Ravi Sreerama **Date:** 08/11/2006

Organization : Dr. Ravi Kumar Sreerama

Category : Physician

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

The proposed changes in the Medicare reimbursement for dual energy x-ray absorptiometry (DXA) should be reevaluated. If adopted, I believe these changes will have a significant negatvie impact on patient access to ostoporosis screening.

Thank You,
Ravi K. Sreerama, M.D.

Submitter : Mrs. **Date:** 08/11/2006

Organization : Mrs.

Category : Physical Therapist

Issue Areas/Comments

Other Issues

Other Issues

August 11, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Subject: Medicare Program; Five-Year Review of Work RVUs under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Doctor McClellan:

My purpose in writing is to comment on the June 29 proposed notice that sets forth proposed revisions to work relative value units and revises the methodology for calculating practice expense RVUs under the Medicare physician fee schedule.

I have been a physical therapist for 26 years and a private practice clinic owner for 1 year in Tacoma, Washington. We have been offering quality physical therapy services to Medicare patients in this clinic for many years, and I, as the new owner, wish to see this continue. Our patients appreciate the dedication and quality care that we offer here. I am concerned with the proposed cuts in reimbursement for physical therapy services will force us to limit patient access and suspect this will be a universal problem, jeopardizing access to care for millions of the elderly and disabled.

Our clinic alone has spent thousands of dollars in the last year educating our staff in regards to Medicare compliance, the new Medicare cap on outpatient physical therapy services, and accessing computer information to establish how many dollars of outpatient dollars each patient has used. I understand that this is part of the practice expense of running a business, and am happy to do what is necessary, but to expect us to accept a cut in payments is simply unfair and unreasonable. Our practice expenses rise every year. Physical therapists spend a considerable time in face-to-face consultation and treatment with patients, yet their services are being reduced in value. The impact of this will be devastating to us and to Medicare patients.

As you know, physical therapists cannot bill for E/M codes and will derive no benefit from increased payment. Increasing payment for E/M services is important, but the value of services provided by all Medicare providers should be acknowledged under this payment policy.

I urge CMS to ensure that severe Medicare cuts for physical therapists and other health care professionals do not occur in 2007 and recommend a transitional change to the work RVUs over a 4 year period to make sure that patients continue to have access to the valuable health care that they need.

Thank you for your thoughtful consideration of this very important matter.

Sincerely,

Jodi Petrinovich, PT

Submitter : Terry Spillers **Date:** 08/11/2006

Organization : Terry Spillers

Category : Individual

Issue Areas/Comments

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

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

The reimbursements cuts that Medicare is proposing for the DXA (76075) will have a negative impact on the doctors in my area. I believe that this cut should be reconsidered with the cost of equipment, staff, license and training that is necessary to perform this test.

Submitter : Ms. Isabel Sklar, LCSW **Date:** 08/11/2006

Organization : Individual private practice

Category : Social Worker

Issue Areas/Comments

Practice Expense

Practice Expense

I am a social worker in private practice and I do work with elderly and disabled patients under Medicare. The availability of counseling for this population is important in reducing the use and expense of other medicare covered services. To reduce the fees of social workers as you have projected is an ineffective way of saving money, since it will negatively impact on the availabiltiy of these services and end up in increased costs to Medicare in other areas.

Many elderly and disabled are isolated, incapacitated, frightened and have minimal resources. The availability of social work services to this population is very important both for the well being of the clients and for taking pressure off the healthcare system. Cutting back on fees for this service will endanger the health and well being of this population.

Submitter : Ms. Cheryl Levine **Date:** 08/11/2006

Organization : Ms. Cheryl Levine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

As a geriatric social worker, who's agency receives reimbursement for mental health services from Medicare I urge the federal government NOT to cut back reimbursements. Seniors in New York who are not Medicaid eligible already struggle for services. This cut back would have a negative impact on the services they already receive.

Sincerely,
Cheryl R. Levine, LCSW
12 W 9th Street Suite 1B
New York, New York 10011
socialworker40@aol.com

Submitter : Dr. Paula Bernstein **Date:** 08/11/2006

Organization : Paula Bernstein, PHD, MD, A Medical Corporation

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

It has come to my attention that Medicare is intending to decrease the global reimbursement for bone density scanning from $140 to $38. Should this enormous decrease take place patient access to osteoporosis screening will be dramatically decreased. I currently lease a bone densitometer for $900 per month. It has allowed me to screen my own patients, diagnose many previously undiscovered cases of osteopenia and osteoporosis, and efficiently give patients results and initiate treatment. Your proposed new reimbursement rate would make it impossible for any individual small practice such as mine to be able to afford to provide this important service.

Submitter : Raj Dalal **Date:** 08/11/2006

Organization : Raj Dalal, M.D.,P.A.

Category : Physician

Issue Areas/Comments

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

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

DEXA has been very effective in diagnosing and monitoring Osteoporosis. I have been doing bone density tests for about 9 years with dual energy DEXA. I have been able to prevent hundreds of hip fractures and spine fractures by use of various medicines. DEXA machines cost about $ 70,000 or more. If CMS reduces from 130 to $ 40 for reimbursement, no doctor will be able to afford a DEXA machine or operator of one. Please consider the value of DEXA in reducing morbidity and mortality of this nation's elderly.

Submitter : **Patricia Tirone** **Date: 08/11/2006**

Organization : **Patricia Tirone**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I am a Licensed Clinical Social Worker with 27 years experience post-masters. I have been in private practice for 14 years and am on numerous provider panels. While my expenses in maintaining my private practice have skyrocketed and my non-billable hours have increased, the reimbursement rates have been decreased at the same time. Simultaneously, the quality of my services and the level of care I provide are superior to what I received in reimbursement rates 14 years ago. It is not acceptable that as the quality of service, the expenses, and the non-billable hours increase, the reimbursement rate decreases. Accepting assignment from insurance companies only serves to benefit the patient while penalizing the provider. With limited hours in every day, it is becoming more difficult for me to continue to accept assignment.

Submitter : Dr. Peter DiCorleto **Date:** 08/11/2006

Organization : Peter A. DiCorleto, M.D., P.C.

Category : Physician

Issue Areas/Comments

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

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

Re: CMS proposed changes in DXA fee schedule

I am a physician in practice in Murfreesboro, TN. I am in a solo Internal Medicine practice and focus on care of the older patient. Most of my patients are Medicare beneficiaries. Over the last several years, I have become increasingly concerned about the rates of osteoporosis in my patients, frequent fractures and poor compliance with osteoporosis treatment. In order to aggressively address this problem, I purchased a dual energy x-ray absorptiometry (DXA) scanner in March of 2006.

With my own DXA scanner, I am able to obtain quality images, increase testing compliance and obtain vertebral fracture analysis. Vertebral fracture analysis (VFA) is a new modality that allows earlier diagnosis of osteoporotic spine fractures. There are no facilities available in Murfreesboro, TN that offers this service to my patients. Having my own scanner also allows me to discuss results with my patients in the office and share with them their scan results. This has dramatically improved treatment compliance. I am in the process of being certified by the International Society of Clinical Densitometry (ISCD) to read scans. None of the local hospitals or imaging centers in Murfreesboro has an ISCD certified reader.

The Centers for Medicare & Medicaid Services (CMS) recently proposed regulations that will dramatically reduce reimbursement for the performance of DXA (CPT code 76075) from the current ~$140 to ~$40 by 2010 and VFA (CPT code 76077) from the current ~$40 to ~$25. These cuts would be in addition to the already-enacted imaging cuts in the Deficit Reduction Act of 2005. These proposed cuts in payment would make in impossible for me to perform DXA and VFA studies in the office, resulting in decreasing my ability to properly care for my patients.

These cuts are at odds with multiple Federal initiatives to reduce the personal and societal cost of osteoporosis. The Bone Mass Measurement Act, the US Preventative Task Force recommendations and the Surgeon General's Report on Osteoporosis all underscore the importance of DXA in the prevention and treatment of osteoporosis. These Federal initiatives, coupled with the introduction of new medications for the prevention and treatment of osteoporosis have improved skeletal health and dramatically reduced osteoporotic fractures. It is the result of these patient directed initiatives, not excessive use of imaging, that have increased the clinical use of central DXA bone densitometry in my practice over the past five years.

The assumptions used to recalculate the Medicare Physician Fee Schedule are inaccurate. I refer you to the International Society of Clinical Densitometry (www.iscd.org) for more information on this subject. In addition these changes would discriminate against communities like Murfreesboro where full service bone density scanning (DXA with VFA read by certified readers) is not available.

I would ask you to address this cut in payments. It is important to the Medicare beneficiaries in Murfreesboro continue to be able to receive high quality medical care.

Submitter : **Anne Shaw** **Date: 08/11/2006**

Organization : **self employed**

Category : **Social Worker**

Issue Areas/Comments

Other Issues

Other Issues

As a clinical social worker, I request CMS not to approve the proposed 'bottom up' formula to calculate practice expense. I request CMS to select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Submitter : Mr. Stephen Johnson **Date:** 08/11/2006

Organization : Behavioral Medicine Clinic

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I work in a rural area and at the present rate of medicare reimbursement have problems meeting expences. over 75% of my practice is with older patients and the total reduction of 14% by 2010 will substantially impact my ability to continue to serve these individuals.

Please do not reduce the amount you pay for clinical social worker services. Those who are covered by medicare deserve to have access to services.

Please withdraw the proposed increase in evaluation and management codes until CMS can increase reimbursement for all Medicare providers.

Stephen J. Johnson LCSW, ACSW

Submitter : Mr. Gilbert Garcia **Date:** 08/11/2006

Organization : Concerned Associates

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1512-PN-1289-Attach-1.DOC

Attach #
1289

Gilbert E. Garcia, MSW, ACSW, LMSW
CONCERNED associates
3612 13th St. Menominee, MI 49858
(906) 864-2208

August 11, 2006

RE: file code CMS-1512-PN

I am a full-time psychotherapist in the Upper Peninsula of Michigan. As an MSW, I provide psychotherapy services for Medicare patients. A 14 % reimbursement will most likely encourage me to discontinue services to those with Medicare, since we provide services to many other third party payors. We also operate an EAP program which provides substantial income on an annual basis. We prefer to serve those with Medicare because of the need, however, lowering the reimbursement would certainly hamper our ability to continue. We foresee such a reduction to gradually eliminate providers for the Medicare covered population.

I am also writing to request CMS not to reduce work values for clinical social workers effective January 1, 2007; requesting CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and requesting CMS not to approve the proposed "bottom up" formula to calculate practice expense.

I urge CMS to select a formula that does not create a negative impact for clinical social workers who have very little practice expense as providers.

Your attention to these concerns is greatly appreciated.

Sincerely,

Gilbert E. Garcia

Submitter : Mr. Fred Jacobson **Date:** 08/11/2006

Organization : Fred Jacobson ans Associates, LLC

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

A 14% reimbursement cut will strongly impact my practice as a Medicare provider and I would request that that cut not be made at present and that the work value reduction due to go into effect on 1/1/07 be withdrawn.
Until reimbursement costs for ALL medicare providers can be increased I'd also request that the increase in evaluation and management codes be withdrawn.
Lastly, I'd request that the "bottom up" formula of calculating practice expense be replaced with a formula that does not negatively impact the clinical social worker, who, by the way, have very little practice expense as providers.
Thank you for your strong consideration to my requests.

Sincerely:

Fred Jacobson

Submitter : Ms. Rosalyn Eig **Date:** 08/11/2006

Organization : SJHC and private practice

Category : Social Worker

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

Withdraw the proposed increase in evaluation and management codes until there are funds to increase reimbursement for all Medicare providers.

Other Issues

Other Issues

Social Workers are providing about three quarters of the countries mental health services. It would be discouraging to receive less in the way of reimbursement... many providers would not be able to continue providing the needed service to long term patients and this could be disruptive and damaging. We would have to find services that are done by less experienced practicioners and usually turnover
is greater and the need for stability and continuity could not be provided to those who really need this service.

Submitter : **Kathleen Bindeman, CRNA** **Date: 08/11/2006**

Organization : **Kathleen Bindeman, CRNA**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Thank you for your time.

Sincerely,

Kathleen A. Bindeman, RN, MSN, CRNA

Submitter : **Mrs. Marni Feuerman** **Date: 08/11/2006**

Organization : **Joel I. Kimmel, Ph.D., P.A.**

Category : **Social Worker**

Issue Areas/Comments

Practice Expense

Practice Expense

A 14 percent reimbursement cut will negatively affect my practice and myself as a Medicare provider for mental health services.
I am requesting that CMS not reduce work values by 7 % for clinical social workers effective January 1, 2007.
I am requesting that CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers. I also
request that CMS not approve the proposed Top down formula to calculate practice expense. I request they select a formula that does not create a negative impact for mental health providers.
Thank you

Submitter : **Dr. Bine Sharne** **Date:** **08/11/2006**

Organization : **Dr. Bine Sharne**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

26. Reg. the practice expense proposal, the codes in the non-work pool have been cut substantially. Practices that utilize these codes will be disproportionately affected. The allocation to the non-work pool should be increased significantly so that these codes are not cut so severely. Investments have been made in equipment based on historical reimbursement, but your proposal would significantly change historical reimbursement for many of these codes.

Submitter : **Dr. Gusto Wingfield** **Date: 08/11/2006**

Organization : **Dr. Gusto Wingfield**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

27. RE: CPT 93701 (practice expense portion). The proposed cut in code 93701 is not something my practice can absorb. I want you to know that I paid over forty thousand dollars for my piece of bioimpedance equipment and we can only use it based on the indication availablde for 2 to 3 times per day. There is no way the equipment cost is being considered correctly in your proposed payment.

Submitter : **Dr. Charles Ray** **Date: 08/11/2006**

Organization : **Dr. Charles Ray**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

28. This comment is in reference to the practice expense section of the 1512 document. I urge you to revise your calculation of CPT code 93701-TC. Based on the equipment cost (I paid $38,700 and new equipment can only be purchased for between $35-$42K) and the frequency in which the equipment can used, the proposed reimbursement amount just doesn t add up.

Submitter : **Dr. Stuart Fisher** **Date: 08/11/2006**

Organization : **Dr. Stuart Fisher**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

PE for CPT 93701. Kindly alter the code amount to reflect real costs of providing the service. The proposed amount is ridiculous.

Submitter : Dr. Christopher Do **Date:** 08/11/2006

Organization : Dr. Christopher Do

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed PE amounts for codes such as 93000 and 93701 will significantly hurt my practice. Codes that have a large technical component are being unfairly reduced in your recent proposal. Delay implementation while the problems are fixed.

Submitter : Dr. Kurt Oelke **Date:** 08/11/2006

Organization : Wisconsin Rheumatology Association

Category : Health Care Professional or Association

Issue Areas/Comments

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

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

see attachment

GENERAL

GENERAL

See attachment

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. Gregory Dilimetin **Date:** 08/11/2006

Organization : Dr. Gregory Dilimetin

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The RUC or survey inputs for equipment cost on CPT code 93701-TC are incorrect. With incorrect inputs, the entire reimbursement amount is incorrect. You have the device cost estimated at $28,625 but the actual cost is $10,000 to $15,000 higher than that. The estimate is based on device technology that was sold in 1998. It is 2006!!!

Submitter : Dr. Hassan Kassamali **Date:** 08/11/2006

Organization : Dr. Hassan Kassamali

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

Using a consistent utlilization rate for equipment for all codes in the physician work pool is a significant flaw in your proposal. A true bottoms up approach would require that actual use be accounted for, not estimated. Codes for equipment used all the time are unfairly high and codes for equipment not used frequently are unfairly low.

Submitter : Dr. Richard Paustian **Date:** 08/11/2006

Organization : Helena Cardiology Clinic

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

I find it amazing that your new practice expense "methodology" for physicians shows that our office overhead is going down. Nothing could be further from the truth! Employee salaries and benefits, insurance costs, energy expenses, equipment purchases and maintainence, supplies and virtually everything else associated with a business are all rising. I was just informed yesterday that I had to spend another $1500.00 to buy a new postage meter because of some new Federal regulation that my current meter did not meet. Computer software must be reprogrammed every year to reflect new requirements even to submit claims to the various carriers. Your methodology that has arrived at the conclusion that overhead expenses are decreasing is seriously flawed. More and more of my collegues are declining to see Medicare/Medicaid patients due to falling reimbursement. This continuing decline will eventually lead to the collapse of medicine as it practiced today since the economic realities of running a business are clearly running counter to the "methodology" which is used to calculate these costs. Please return to reality and look around.....do you see ANYTHING that costs less now than 1-2 years ago? Please try to sharpen your pencils and get this correct. If you wish to see what a real practice is like in rural America, contact me and I will be happy to show you.

Submitter : Dr. Rafic Jarrah **Date:** 08/11/2006

Organization : Dr. Rafic Jarrah

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

You need to alter your supplies input for CPT 93701-TC. The actual cost is $10.95 for four dual sensors which make up on patient application/test, plus tax ($0.80) plus shipping (about $0.25 per application). Please verify with the manufacturer at 800-778-4825. This mean the actual amount is $12.05 vs. your quoted $9.95. $2.05 difference may seem small but these small errors in calculation add up to unfair reimbursement for the code.

Submitter : **Dr. Elda Kadymoff** **Date: 08/11/2006**

Organization : **Dr. Elda Kadymoff**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

The frequency of equipment use component into your practice expense must be applied based on the individual code s frequency, not a standard use for all equipment. Your current method is akin to taking the average equipment cost for all equipment and applying the same cost to all codes. That obviously doesn t make sense, so neither does your current frequency of use assumption.

Submitter : Ms. **Date:** 08/11/2006

Organization : Ms.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

A 14 percent reimbursement cut will affect my practice and me as a Medicare provider, as well as all of my colleagues;
I request that CMS not reduce work values by 7 % for clinical social workers effective January 1, 2007;
I request CMS to withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers; and
I request that CMS not approve the proposed Top down formula to calculate practice expense. I request they select a formula that does not create a negative impact for mental health providers.

Submitter : Dr. Maile Kane **Date:** 08/11/2006

Organization : Dr. Maile Kane

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed PE amount for CPT code 93701-TC will go down about 1/3 by 2010. This does not equate with the high costs of providing this procedure on a somewhat limited patient population of heart failure. This is only one or two patients per day in our practice. Please alter something in your calculation so that the amount is reasonable for the costs of performing the test.