Submitter : Dr. Lawrence Phillips

Date: 07/26/2006

Organization : Dr. Lawrence Phillips

Category : Physician

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

As a cardiology fellow-in-training, I have the unique perspective of having just finished an internal medicine residency as well as entering a subspecialty with many procedures. I believe that the increased reimbursement for Evaluation and Management Services is an important step in making sure that all patients will be able to receive both basic, routine care as well as find physicians, be they general practitioners or subspecialists, to act in the role as their "primary" physician.

Submitter : **Date: 07/26/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

It has come to my attention that medicare reimbursement for CPT 93701 is due for a cut next year. I am a cardiologist in a rural area and heavily rely on bioimpedence technology in managing patients as an outpatient rather than just admitting the patient to the hospital because "it's a complicated patient and it's taking me too long to figure out what's going on and the easy way out is just admit the patient and then figure it out". I suppose that is one way of practising but one that is more costly and patient's deserve a more thoughtful physician. Having said that, the last time I checked, my office staff weren't asking for a decrease in pay, the inflation wasn't going down every year, the malpractice wasn't decreasing and the cost of equipment wasn't decreasing. However, what has been decreasing is the reimbursement for services by medicare making it very difficult for providers to continue to offer greater technological services especially in the rural areas where it has been difficult for patients to get the services and it has been difficult for patients to neighboring cities due to poverty, age or difficulties with transport. One sure way to drive physicians and services away from these rural areas is to continue to cut reimbursements. The larger practices in larger cities will find ways to survive but the victims will be the people in the small cities and rural areas.

I urge you to reconsider not only the cut for this CPT but also to consider other cardiovascular CPTs where the costs continue to rise but reimbursements continue to decline. Please don't let the patients in smaller towns be the victims.

Submitter : **Dr. Ali Afrookteh** **Date: 07/26/2006**

Organization : **Internal Medicine Associates**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

I am 1 of a group of 7 internal medicine physicians practicing in Frederick, MD. We have approx. 30,000 patients in our practice. We have a support staff of over 30 people. Atleast 50% of our practice is Medicare beneficiaries and we see our patients in the office, local hospital, local nursing homes and occasionally home visits.

Our typical patients are elderly, have multiple medical problems and many are on fixed incomes. These patients require multiple interventions throughout the year. We have dedicated staff to schedule their tests and subspecialty referrals as they have great difficulty in doing these complex and confusing tasks themselves. Frequently, we speak to them or their family members by phone. We also speak to many ancillary providers such as physical therapists as well as subspecialists to coordinate their care. This takes a great deal of time.

None of this care outside the face to face interaction is reimbursible. Medicare guidelines currently state that this is factored into the fees of the visit but doesn't even come close. As a matter of fact reimbursement for evaluation and management services has been very low despite rising cost for internists and other primary care practioners.

In the state of Maryland, no one in the internal medicine residencies of the University of Maryland and Johns Hopkins this year was going into general internal medicine. The reason cited by the residents, poor reimbursement given the demanding and long hours of the profession.

However, internists and family physicians are the linch pin of cost effective care for the elderly. More time spent with the patient in evaluation, management and coordinating care with the various subspecialists and ancillary personnel saves money and improves the health of the patient. Less tests are ordered, redundancy is decreased, referrals to specialists are reduced. Also more time can be spent in coordinating care with the families.

This will not take place without a significant improvement in reimbursements for E & M services. As overheads rise and reimbursements fall behind, doctors will close their doors to new Medicare patients (already happening in our community) and some physicians will get out of the system altogether (also happening in our community).

For the years ahead, the demands for primary care services will increase significantly given the retiring and expectations of the baby boom generation. We need to have internists and family practioners ready and willing to take on the complex task of treating these people. Without a significant improvement in reimbursement including covering for the coordination of care services as well as increasing office, nursing home and hospital reimbursements, we will not have these physicians available. Then care costs will rise as they will be delivered by more expensive subspecialists, procedures will be increased and more acute care will be delivered in higher cost settings such as the emergency room and in hospital.

I and my collegues strongly ask you to approve the recommendations of CMS and increase reimbursements for evaluation and management services.

Sincerely,

Ali J. Afrookteh, MD, FACP

CMS-1512-PN-849

Submitter : Dr. Louis Schlickman **Date:** 07/26/2006

Organization : Meridian Adult Medicine, PLLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

RE: Work RVU changes for Evaluation and Management codes.

Dear Sir or Madam:

I am urging CMS to implement the proposed E/M work RVU changes in the 2007 Medicare physician fee schedule. This will clearly have a positive impact on primary care practices throughout our area in Boise, ID.

As an internal medicine adult medical specialist I am constantly confronted by people with multiple and complex illnesses. It is quite common that I will have to address these issues collectively due to the interplay of potential complications among these various entities. Our technology and knowledge base utilized in today s practice of medicine necessitates application of these tools to address things such as high blood pressure, diabetes, high cholesterol, kidney failure, and heart disease--all frequently in the same visit.

With my large amount of Medicare patients (the age in which multiple and complex medical problems will usually be happening) approaching 55% of my total patient load, this current proposed work RVU increase will allow me to delay or avoid closing my practice to any new or established Medicare patients. Currently I am undergoing some strain in my solo practice and I am now temporarily refusing to see new Medicare patients because the amount of resources required to care for them are easily taxing my ability to keep my solo practice open. The time commitment is often extensive and the financial reward is always dismal when one realizes the rapidly rising overhead costs to my specialty. This work is shamefully under-reimbursed.

For a little over 2 years I have felt compelled not to limit my Medicare population due to the lack of Medicare providers in our area. However, I now find myself having to make the difficult decision to do just that to maintain solvency of the business aspect of my practice. I am one of the very few private practices in the Boise, ID area who have tried not to limit Medicare. That includes all solo and small group internal medicine and family practice entities in our area. The only groups I m aware of who have no limitations are those owned by hospitals, affiliated with residency programs or have a safety net designation to allow modestly helpful extra funding (along with help from volunteers) to care partly for these Medicare patients. These groups, of course, are already strained by the other patient groups competing for access to care such as Medicaid, the uninsured, and the underinsured.

While we all endeavor to try to correct our woefully inadequate system of healthcare delivery to all our US citizens, this RVU adjustment will at least have a serious, albeit limited, benefit to those of us trying to do our best to provide comprehensive and complex adult primary care in our area. The type of care shown to be cost effective in reducing the financial burden associated with the untreated preventable disease that is incurred by inadequate access to such primary physicians skilled in caring for this population.

I am aware that you will receive comment from other groups in protest of this position likely due to the budget neutrality issue that may lead to a decline in their reimbursement. I would ask that you reject any comments that would lower the overall improvements in work RVUs for E/M services. Although this is not meant to claim that those other services are less worthy, it most certainly is a profound claim that E/M services involving intense cognitive based care are definitely worthy of an improvement in reimbursement.

Please, I again urge you to finalize the recommended work RVU increases for evaluation and management services. Thank you for your consideration.

Sincerely,
Louis M. Schlickman, MD

Submitter : Dr. Barry Schultz **Date:** 07/27/2006

Organization : Barry M. Schultz, MD, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam:

On behalf of myself and the patients I serve, I urge CMS to implement the proposed E/M work RVUs into the 2007 Medicare Physician Fee Schedule.

As you know, these changes were initially proposed by an AMA-sponsored workgroup of primary care, surgical, and other specialty physicians. It is impressive that a workgroup with such disparate membership has this emerged with the consensus that the current RVU rates for these services is grossly inadequate and therefore discourages physicians from providing the type of follow-up care that represents the best practice of medicine. By accepting the proposed changes, CMS would be encouraging physicians to provide the best care possible.

I urge CMS to accept the proposed changes and incorporate them into the 2007 Medicare Physician Fee Schedule.

Submitter : **Dr. Barry Schultz** **Date: 07/27/2006**

Organization : **Barry M. Schultz, MD, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam:

On behalf of myself and the patients I serve, I urge CMS to implement the proposed E/M work RVUs into the 2007 Medicare Physician Fee Schedule.

As you know, these changes were initially proposed by an AMA-sponsored workgroup of primary care, surgical, and other specialty physicians. It is impressive that a workgroup with such disparate membership has this emerged with the consensus that the current RVU rates for these services is grossly inadequate and therefore discourages physicians from providing the type of follow-up care that represents the best practice of medicine. By accepting the proposed changes, CMS would be encouraging physicians to provide the best care possible.

I urge CMS to accept the proposed changes and incorporate them into the 2007 Medicare Physician Fee Schedule.

Submitter : Dr. Christopher Sirard **Date:** 07/27/2006

Organization : UC Davis Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The field of anesthesiology has waited and waited for appropriate reimbursement. Now, instead of increasing payments to post-1970's levels, we will receive even less. Please don't force hospitals and surgeons to push Medicare/Medicaid patients away. Increase anesthesia reimbursement to more reasonably reflect how we save the lives of many of these needy individuals. Thank you.

Submitter : **Dr. Margaret Grossman** **Date: 07/27/2006**

Organization : **Dr. Margaret Grossman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the proposed rule to increase the work relative value units assigned to Medicare Evaluationa dn Management codes, as recenly proposed by the Center for Medicare and Medicaid Services. As a Family Physician, I am one of a large group that provides essential services to many Medicare benficiaries, and the related costs have increased significantly in the last 10 years.

Submitter : **Dr. Brian Birmingham** **Date: 07/27/2006**

Organization : **University Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider the outdated methodology leading to undervaluation of anesthesiologist's services and the resulting huge cuts planned for reimbursement for anesthesiologists. Such cuts only further endanger access to high quality anesthesia care that all our citizen's deserve.

Submitter : **Dr. Laura Kihlstrom** **Date: 07/27/2006**

Organization : **Atlantic Anesthesia, Inc.**

Category : **Physician**

Issue Areas/Comments

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

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

Dear Sir or Madam,

I am a practicing anesthesiologist. I interact with virtually every other medical specialty to take excellent care of patients. My primary concern is patient safety. What I do is technically and intellectually demanding. To maintain safety, we must use sophisticated equipment, and have highly trained assistants and employees.

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.

Thank you for your attention.
Laura Kihlstrom M.D.

Submitter : **Dr. Adam gallucci** **Date: 07/27/2006**

Organization : **anesthesia associates of springfield**

Category : **Physician**

Issue Areas/Comments

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

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

I must strongly protest the projected cuts to anesthesiologists amounting to 10% over the next few years. My corporation provides services to Mercy Medical Center in Springfield MA. We serve a largely indigent population and Medicare/Medicaid amounts to about 60-65% of our patients. Over the last 2 years, our total revenue has fallen about 3% each year, and expenses rise at let as fast as inflation does. This has caused our MD salaries to fall every year for the last two years. Last year alone my salary was down 12% from the year before. The net result of this is that we are unable to attract new MDs despite a critical need. They go elsewhere because salaries are higher elsewhere. I presume you care nothing about my salary, but you should care that in the forseeable future, we will have to signifgicantly curtain services to poor patients because we will have no anesthesiologists willing to work here. Iwould welcome a chance to further discuss this issue
Adam A Gallucci, MD C/O Anesthesia Associates of Springfield, P.O. Box 2608, Springfield, MA 01109 email agallucci@yahoo,com

Submitter : **Date: 07/27/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed RVU amount for CPT code 93701 is unacceptable and inappropriate. The new methodology used to calculate the RVU amounts for practice expense for this code will result in a significant decrease in the reimbursable amount. This is not compatible with increasing practice expenses for the procedure. As you probably know, equipment prices are increasing across the board, not decreasing. Prices for disposable equipment are also increasing, as are technician costs and overhead. This proposed change in RVU amount will eventually affect all healthcare workers; the "bottoms up" methodology is obviously a ploy to decrease reimbursement, and if allowed to proceed in this instance, will probably be utilized universally in the future.

Submitter : **Dr. Solon Finkelstein** **Date: 07/27/2006**

Organization : **Palo Alto Medical Clinic**

Category : **Physician**

Issue Areas/Comments

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

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

I am writing to strongly object to proposed cuts in the technical component for CAD and steriotactic breast biopsy and the lack of cuts in digital mammography. I have had extensive experience with mammography and CAD. I have personally read over a quarter of a million mammograms in 40 years of practice and used CAD since its inception 12 years ago. We were among the first to use steriotactic core breast biopsy and were one of the few places that were able to use it to completely replace open biopsies from the start. We have published extensively on our breast experience.

CAD detects early, otherwise missed cancers and needs to be encouraged. New prospective data (see Dean and Ilvento AJR:187, July 2006 and Morton et. al. Radiology:239, May 2006) confirm more cancers detected with CAD. CAD is expensive and more important, takes significant time and effort to do. The films need to be digitized and the data incorporated into the reading system. There is no justification to reduce the RVUs

Steriotactic breast biopsy saves money, and promotes better, faster, safer, breast care. The equipment continues to improve and the costs of the new equipment as well as the cost of needles, localization clips, disposable containers, etc. continues to increase. There is a justification for increasing the RVUs and certainly no justification for the huge proposed decrease.

On the other hand, the lack of change in the RVUs for the technical component of digital mammography makes no sense. Another recent paper (see Berns et al. AJR:187 July 2006) points out that digital mammography is faster and easier then film mammography for technologists. The time and effort for the radiologist is significantly more and there is therefore some justification for increasing the work RVUs but certainly not the technical RVUs.

I hope these proposed changes will be drastically revised.

Solon Finkelstein
Palo Alto Medical Clinic
795 El Camino Real
Palo Alto CA, 94306

Sfinkelstein@pamf.org
650-853-2955

Submitter : Dr. Amer Zarka **Date:** 07/27/2006

Organization : Coastal Heart Medical Group

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The new methodology used to calculate the RVU amounts for practice expenses for CPT 93701 results in a significant decrease in reimbursable amount that is not compatible with increasing practice expenses for the procedure.

1. Thoracic Bioimpedence equipment prices are increasing
2. Thoracic Bioimpedence disposable prices are increasing
3. Technician costs are increasing
4. overhead is increasing.

Submitter : **Dr. Anil Shah** **Date: 07/27/2006**

Organization : **Coastal Heart Medical Group**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

The new methodology used to calculate the RVU amounts for practice expenses for CPT 93701 results in a significant decrease in reimbursable amount that is not compatible with increasing practice expenses for the procedure.

1. Thoracic Bioimpedence equipment prices are increasing
2. Thoracic Bioimpedence disposable prices are increasing
3. Technician costs are increasing
4. overhead is increasing.

Submitter : **Dr. George Woodrum** **Date: 07/27/2006**

Organization : **Dr. George Woodrum**

Category : **Physician**

Issue Areas/Comments

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

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

It is disturbing that CMS is again unfairly targeting anesthesiologists with further cuts in reimbursement. Like all citizens, our cost of living is gradually increasing, and yet our reimbursement is continually decreasing. We cannot increase our volume of business to offset these losses. This type of behavior makes it less and less desirable to care for our elderly population, as it is becoming less and less worth our time.

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

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

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

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

Most importantly, 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. Kelly Conaty** **Date: 07/27/2006**

Organization : **Pediatric Anesthesia Associates, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Attention: CMS-1512-PN

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

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

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

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

Thank You;
Kelly R. Conaty, MD

Submitter : **Dr. Phiip Balestrieri** **Date: 07/27/2006**

Organization : **University of Virginia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

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

Submitter : Dr. Joshua Aaron **Date:** 07/27/2006

Organization : Regional Pulmonary and Sleep Medicine

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed RVU amount for CPT 93701 (TEB) is too low and cannot be justified given current expenses of administering the test. The new methodology used to calculate the RVU amounts for practice expense for 93701 results in a significant decrease in the reimburseable amount for the test that is simply not compatible with increasing actual practice expenses for the procedure. Disposable prices are increasing, equipment prices are increasing and are significantly greater than the amount CMS has estimated, staff salaries are increasing. CMS should maintain or increase the practice expense RVU amount from its current level of 0.98.

Submitter : **Dr. Mukesh Nigam** **Date: 07/27/2006**

Organization : **Danville Regional Medical center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

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.The inflation is not even taken in account as well as routine life expenses.

CMS should extract new overhead expense data to replace the
decade-old data and technique currently being used.
ASA, many other specialties, and the AMA are committed to
financially support a comprehensive, multi-specialty practice expense
survey. CMS should take immediate action to launch this much needed
survey which will greatly improve the accuracy for all practice expense payments.
CMS must address the issue of anesthesia work undervaluation
or our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine, which is already seem to be on horizon and there should be sufficient compensation to our stressful and highly skilled specialty to attract young physicians in the future. Any attempts to cut fee schedule would adversely affect this integral part of medicine.

Submitter : **Dr. James Vogus** **Date: 07/28/2006**

Organization : **James B. Vogus, M.D.**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

I was pleasantly surprised to learn of the possibility of a increase in the Evaluation and Management fees (based on work value units). With an aging population and much sicker(and therefore work-intensive) patients, family physicians are forced to provide more care with less reimbursements. New physicians are avoiding the primary care specialties as they recognize the low payments for heavy responsibilities. Also, dramatically rising office costs siphon away any trivial gains made with efficiency methods.

If America hopes to have a viable physician workforce in place for the basic care of myriad senior citizens, steps like increasing the value of that care may help reverse the falling numbers of primary care doctors. Thank you.

Submitter : **Dr. Jason Goldman** **Date: 07/28/2006**

Organization : **Florida Chapter American College of Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam:

On behalf of myself and the patients I serve, I urge CMS to implement the proposed E/M work RVUs into the 2007 Medicare Physician Fee Schedule.

As you know, these changes were initially proposed by an AMA-sponsored workgroup of primary care, surgical, and other specialty physicians. It is impressive that a workgroup with such disparate membership has this emerged with the consensus that the current RVU rates for these services is grossly inadequate and therefore discourages physicians from providing the type of follow-up care that represents the best practice of medicine. By accepting the proposed changes, CMS would be encouraging physicians to provide the best care possible.

I urge CMS to accept the proposed changes and incorporate them into the 2007 Medicare Physician Fee Schedule.

Submitter : **Dr. Rohit Bhave** **Date: 07/28/2006**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a concerned physician, I would like to comment on the proposed cuts in funding for Anesthesiology. I am particularly worried that the SGR formula to support the funding cuts is outdated. The undervaluation of the impact of anesthesiology on patient care negatively affects many critical areas. Beyond our vital role in the OR, we care for extremely sick patients in GI suites, interventional radiology suites, and in the ICU. Many of these patients are much too sick to be touched by surgery--their presence in minimally invasive procedures means they require very competent anesthesiologist to ensure safe outcomes. Numerous studies in the ICU have confirmed better outcomes and reduced costs with a dedicated attending ICU-trained anesthesiologist.
Lastly, I fear vital cuts to Anesthesia are being used to pay for increased overhead present in other specialties. As someone trained to place the patient first, I fear these funding changes will severely undermine safe patient care. As a citizen, I fear these changes will place my family and friends in greater harm when they go to the hospital. In light of these thoughts, I propose an increase of 2.8%, a number supported by MedPAC.

Submitter : **Date: 07/28/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I object to another reduction in the already minimal reimbursement for CPT 93701, Bio-Z. Your original cost estimate of the machine was way under actual cost, and prices for equipment and technician costs continue to rise. Are you trying to run us out of business? You demand that we practice the best available level of care, yet you refuse to pay what that care is worth!

Submitter : **Dr. Christine Zainer** **Date: 07/28/2006**

Organization : **self**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a physician in an academic practice that trains future anesthesiologists who are much needed. We do not make extravagant salaries. We are committed to patient care and education. Further cuts will be extremely deleterious to all including patients.
As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the overhead cost increases for a handful of specialties.
The proposed change in PE methodology hurts anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses.
CMS should gather new overhead expense data to replace the decade-old data currently being used.
ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments.
CMS must address the issue of anesthesia work undervaluation or our nation s most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine.

CMS-1512-PN-870

Submitter : **Dr. Michael Crawford** **Date: 07/28/2006**

Organization : **Dr. Michael Crawford**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Information obtained from BioZ (CPT 93701) is very helpful for diagnosis and medical treatment of my patients. I feel the RVU is too low as proposed, as cost of doing test has increased. Please do not decrease the reimbursement of this useful test. Thank you.

Submitter : **Dr. Carl Ferguson** **Date: 07/28/2006**

Organization : **Dr. Carl Ferguson**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed RVU ammount for CPT code 93701 is not acceptable, I do not feel this reduction fairly incorporates the cost of my equipment i.e. $45,000, nor the cost of disposables- approximately $10 per test. Technician costs as well as general overhead is increasing, not decreasing! Your equipment cost estimate of $28,625 is grossly underestimated!

Submitter : **Dr. Michael Springer** **Date: 07/28/2006**

Organization : **Medical Center Cardiologists**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed amount allowable is not work-able. The ICG equipment supplies are more expensive thank the $28,000 and $10 cost estimates that CMS is using, HELP!!! The RVU amount should be increased from its current 0198 to 1.08 or 1.18, not decreased!

Submitter : **Dr. Robert Lee** **Date: 07/28/2006**

Organization : **Nephrology Associates**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I find TEB technology valuable. Please do not decrease the current amount allowable for reimbursement for CPT code 93701. The overhead and equipment cost is high and I need at least the current ammount to justify continued use. Moving the RVU to 0.71 by 2010 will make procedure impossible to perform without loosing money.

Submitter : Dr. John Butterworth

Date: 07/28/2006

Organization : Dr. John Butterworth

Category : Physician

Issue Areas/Comments

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

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

The proposed update will be unfair. It will penalize anesthesiology disproportionately compared to other specialties. It is illogical to reduce the reimbursement to anesthesiology so as to cover the overhead costs of other specialties. Indeed the practice expense formula for anesthesia is dated and needs to be updated.

Submitter : **Dr. Mark Mandabach** **Date: 07/28/2006**

Organization : **U. of Alabama @ Birmingham Dept of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS-proposed changes to Physician Fee Schedule include substantial cuts to anesthesiology

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

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

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

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

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

Submitter : **Dr. Jack Kleid** **Date: 07/28/2006**

Organization : **San Diego Heart and Medical Clinic, Inc**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

Your proposed RVU amount for CPT code 93701 is not appropriate or acceptable. The new methodology used to calculate the RVU amounts for practice expense for CPT code 93701 will result in a significant decrease in the reimburseable amount that is not campatible with the increasing "practice expenses". Equipment, disposable supplies, technician costs, malpractice insurance, as well as general office overhead, continue to increase. Please consider all of these facts before implementing the significant decrease in the RVU amount for CPT Code 93701. Thank you.

Submitter : **Dr. bruce kleinman** **Date: 07/28/2006**

Organization : **Dr. bruce kleinman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

the cuts in anesthesia related services will have major negative impact in this nation's ability to provide surgical and critical care to a soon to be retired and older citizenship - specifically many of the "baby boomers." Cuts in anesthesia services will also adversely affect the many millions of our citizens trying to cope with chronic pain.

Submitter : **Dr. Wayne Graff** **Date: 07/29/2006**

Organization : **Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

My understanding is that there will be a substantial reduction in the payments to Anesthesiologists in the upcoming years. While I appreciate your need for budget neutrality, the idea that physicians need to make up deficits in funding is wrong. To provide the kind of care Americans desire and deserve will require adequate funding. Eventually, with lowering salaries the quality of physician will fall. Even if there was no reduction of payments, with inflation there is a relative decrease in the value of the payments.

Submitter : **Dr. Michael Murphy** **Date: 07/29/2006**

Organization : **Carson City nephrology**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

As a solo practitioner in primary care in a relatively small community, as well as a solo specialist (Nephrologist), I provide care to many elderly patients with Medicare coverage and without any other reasonable source of payment for healthcare services. Sadly, it has become increasingly difficult for most of my patients to access medical care in this area because of the fact that primary care physicians and subspecialty medical practitioners can no longer afford to keep their doors open to patients with Medicare coverage. As a result, I would strongly encourage full adoption of this resolution for the 2007 budget for the Medicare fee schedule. This measure, and hopefully more like it in the future, will allow patients much better access to the care that they deserve!
Thank you!

Submitter : **Edmund Garvey** **Date: 07/29/2006**

Organization : **Edmund Garvey**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

With required budget neutrality, the proposed changes to the Physician Fee Schedule for practice expense methodology and physician work values will cause huge payment cuts for anesthesiologists. These changes hurt anesthesiology more than most specialties, because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly underestimate actual expenses for anesthesiology. New data should be collected to replace the decade old data currently being used. The American Society of Anesthesiologists and many other societies, including the American Medical Association, are committed to financially supporting a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy for all practice expense payments. CMS must address this issue of work undervaluation for anesthesiology or Medicare patients, our nation's most vulnerable population, will face a certain shortage of anesthesiologists in operating rooms, pain clinics and critical care units.

Submitter : **Dr. Eric White** **Date: 07/29/2006**

Organization : **Capitol Anesthesiology Association**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

The CMS's proposed new practice expense methodology recommends a 6% cut to overall payments to anesthesiologist this year with additional 1% decreases each year until 2010. This huge payment cut is to supplement other specialties overhead cost increases. This is a potentially crippling blow to our specialty as many practices are based in large hospitals and have percentages of Medicare/Medicaid patient populations approaching 50% of their total. While I appreciate that medicine continues to get more expensive and no one wants to pay for it, we as anesthesiologist continue to be faced with older, sicker patients than even 10 years ago. Their medical management in the operating room is more complex and demanding than ever. Decreasing our payments grately undervalues the challenges of caring for a aging, medically complex population. This can only lead anesthesiologist being forced to leave hospital situations where they take care of many Medicare patients. We should be trying to keep the skilled practitioners in these locales and the only way to do that is to keep the compensation fair.

Submitter : **Date: 07/30/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

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.

Submitter : **Dr. Kathleen ayaz** **Date: 07/30/2006**

Organization : **Abbot Northwestern General Medicine Assocaites**

Category : **Physician**

Issue Areas/Comments

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

Discussion of Comments- Evaluation and Management Services

As a practicing General Internal Medicine specialist, I would like to encourage an "upgrade" of the RVU scale used for routine office visits(E/M codes). Currently internists(and all primary care providers) are being undercompensated for services provided. There is a growing trend to choose specialties other than primary care fields because of the growing desparity between compensation in the primary care versus specialty fields. There are many services provided in the primary care office(i.e. telephone triage/prescription refills over the phone/weekend emergancy call services, etc) that are completely uncompensated as there are no "billing codes" to cover these types of services, yet these services are an integral part of primary care. Therefore , I strongly feel that unless the billable services(E/M codes and RVU attached to them) are upgraded, there is indeed an impending crisis in the primary care field.
Thank you for your consideration.

Submitter : Dr. Lawrence Kilinski **Date:** 07/30/2006

Organization : Dr. Lawrence Kilinski

Category : Physician

Issue Areas/Comments

Other Issues

Other Issues

It is blatantly unfair and discriminatory to subsidize fee increases in certain subspecialties by reducing fees in otherwise underfunded other subspecialties such as anesthesiology. Anesthesiology has traditionally been legislatively forced to hugely discount services to government subsidized patients at a level not covering expenses. Requiring a "Budget neutral" position for fee changes is not addressing the fact that overhead expenses are increasing as well as increased cost-of-living for all Americans, including physicians.

My understanding is that the data supporting such action is outdated and inaccurate. It is also my understanding that organized medicine such as the American Society of Anesthesiologists, American Medical Association and other subspecialty organizations of medicine are willing to fund survey projects that can accurately provide updated information concerning the practice costs to physicians and appropriate fee reimbursement formulas that can be fair for all parties, not just to a select few. As a physician and an American, I demand fairness and equality. As a governmental agency, you should too.

Submitter : Dr. ali balanon **Date:** 07/30/2006

Organization : Dr. ali balanon

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Dr. Mark Dougherty** **Date: 07/31/2006**

Organization : **Union 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 increases for a handful of specialties. This would amount to a 10% cut in Medicare payments to anesthesiologists over the next four years.

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

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

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

? CMS must address the issue of anesthesia work undervaluation or our nation s most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and throughout critical care medicine. The goverment pays one third the rate of private payers. Due to low goverment payments over one half of anesthesia groups run in the red and must recieve a supplement from the hospital to continue to practice.

Submitter : **Dr. Howard DeHoff** **Date: 07/31/2006**

Organization : **Lehigh Valley Physicians Group**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

I practice general internal medicine in
Allentown, Pennsylvania. Many of my encounters with patients are predominantly for diagnostic and therapeutic management of complex chronic conditions. For successful management to occur, I must devote a large component of my time with this type of patient providing instructional, informational and counselling services. There are no 'quick fixes' for the epidemics of chronic diseases such as diabetes, obesity, hypertension, stroke, dementia and depression that general internists encounter in a majority of their patients. It takes our time energy and resources to provide each patient the necessary evaluation and management of their health problems that interfere with their daily lives. We need to be adequately and fairly compensated for our efforts. There is a growing shortage of general internists. I see our residents in traing opt out of careers in genral medicine in favor of more lucrative careers in sub-specialties such as cardiology, gastroenterology and pulmonology and the driving force is a negative one: lack of adequate compensation for their effort in general medicine. The nation's health is truly at stake. Increasing our compensation for our valuable cognitive services is a step in the right direction.

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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. Gary Fischer** **Date: 07/31/2006**

Organization : **University of Pittsburgh**

Category : **Physician**

Issue Areas/Comments

Discussion of Comments- Evaluation and Management Services

Discussion of Comments- Evaluation and Management Services

I am an internist who takes care of many Medicare patients in Pennsylvania. I also am involved with teaching medical students and residents, and have the opportunity to learn from them the factors that are influencing their choice in career.

There is no question that since I started practicing medicine 11 years ago, the patients that I care for are increasingly complex. This is because medical advances has allowed patients to live with multiple, more severe, chronic diseases for longer, and to live out satisfying lives with these diseases. It is also because there are newer therapies available that are very beneficial, but increasingly complex to manage.

Because of this, I fully support the planned increases to the work RVUs for Evaluation and Management Services.

Looking to the future of the physician workforce, there is no question that future physicians (students and residents) look closely at the disparity between the compensation of procedural specialists and those provide continuity care to very complex patients. This causes many who would otherwise be interested in providing primary care, to choose procedure-based specialities as well. The proposed changes are a good first step to helping to ensure a primary care physician workforce for the future.

Submitter : **Dr. Steve Pusker** **Date: 07/31/2006**

Organization : **Greenville Anesthesiology, P.A.**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

The proposed Practice Expense methodology change unfairly burdens anesthesiologists and other specialists as a means of supplementing overhead cost increases for a variety of other specialties. This might be reasonable if anesthesiologists were properly reimbursed via the Medicare system, but thanks to the CMS decision to arbitrarily lower the Conversion Factor for our services in 1992, we are now paid less in absolute and inflation-adjusted dollars than we were 15 years ago. In fact, anesthesiologists are paid less than 40% of what private insurers pay, which is approximately half the amount paid to ALL other medical specialties. Coupled with the proposed long-term decreases in physician reimbursement imposed by the Sustained Growth Rate formula, our specialty faces a crippling blow in reimbursement at the hands of CMS and the federal government. We hope that you will reevaluate this proposal and I urge you to reverse this decision before anesthesiologists begin to decline services to Medicare patients in operating rooms, pain clinics, and critical care medicine.

Submitter : **Dr. William Burk** **Date: 07/31/2006**

Organization : **Greenville Anesthesiology, P.A.**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I am writing to oppose the proposed Practice Expense methodology change, which unfairly burdens anesthesiologists and other specialists as a means of supplementing overhead cost increases for a variety of other specialties. For almost 15 years anesthesiologists' services have been undervalued because of the Conversion Factor, a decision made (yet again) by CMS in the early 1990s. We are now paid less in absolute and inflation-adjusted dollars than we were in 1990, and anesthesiologists are paid less than 40% of what private insurers pay, which is approximately half the amount paid to every other medical specialty. Combined with the proposed long-term decreases in physician reimbursement imposed by the Sustained Growth Rate formula, our specialty faces a destructive decrease in reimbursement at the hands of CMS and the federal government. We hope that you will reevaluate this proposal and I urge you to reverse this decision as you gather the pertinent facts.

Submitter : **Dr. Michael Evans** **Date: 07/31/2006**

Organization : **Greenville Anesthesiology, P.A.**

Category : **Physician**

Issue Areas/Comments

Practice Expense

Practice Expense

I am writing to express my opposition to the proposed Practice Expense methodology. This change unfairly burdens anesthesiologists and other specialists as a means of supplementing overhead cost increases for a variety of other specialties. As you all know well, anesthesiologists are improperly reimbursed via the Medicare system, thanks to the CMS decision to arbitrarily lower the Conversion Factor for our services in 1992. In fact, we are now paid less than we were 15 years ago. Sadly, anesthesiologists are paid less than 40% of what private insurers pay, which is approximately half the amount paid to ALL other medical specialties. Coupled with the proposed long-term decreases in physician reimbursement imposed by the Sustained Growth Rate formula, our specialty faces a crippling blow in reimbursement at the hands of CMS and the federal government. We hope that you will reevaluate this proposal and I urge you to reverse this decision before anesthesiologists begin to decline services to Medicare patients in operating rooms, pain clinics, and critical care medicine.

Submitter : **Dr. Ian Kucera** **Date: 07/31/2006**

Organization : **Anesthesia Associates of Topeka**

Category : **Physician**

Issue Areas/Comments

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

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

This is in regards to proposed changes to the physician fee schedule for anesthesiology. The current recommendation suggests a 6% cut in total payments to anesthesiologists and a 1% cut every year thereafter for 4 years resulting in a 10% decrease in reimbursement over the next 5 years.

The major problem with these recommendation is the outdated and incorrect data used to calculate practice expenses. One of the major expenses not taken into account is the expense related to inefficienies in OR's. My group has 18 employed CRNA's, because of uneven surgical scheduling, turnover times in OR's, and unforseen events our CRNA's only are able to bill for approximately 60% of the time they are at work. This is an expense to the group which is not incorporated into CMS's calculations. Obviously we are paying our employee's while they are not able to work during the day because of inefficiencies in the OR which are out of our control. Obviously, the degree of inefficiency will vary from OR to OR, however, there is general agreement that 75% is the best that can be hoped for, and 60% is more likely the average.

Medicare is certainly not responsible for the fact that we are not able to bill for our entire day of work; however, if you are trying to truly base payments on expenses of a practice, you must take this into consideration when determining payment schedules.

An example of potential income from an anesthesia provider caring for medicare patients in a given year working 8 hours a day being maximally efficient in our OR (60%) would yield the following income

8 * 60% = 4.8 billable hours per day
4 units per hour gives 19.2 units per day
add additional 16 units per day for the base units per case gives a total of 35 units per day.

Calculate 4 weeks of vacation a year gives a total of 7700 units per year.

At the recommended cuts the new amount per unit would be about $15.03.

This yields a gross income of 115,731. Out of this we will pay approximately 10% for billing and collection expenses, an additional $12,000 per year for malpractice.

This would leave you with $92,000. Health insurance premiums, office adminitrative expenses, medical education expenses, funding a retirment plan and several other significant expenses which vary greatly from practice to practice have yet to be deducted.

As a reasonable estimate this would leave one with about $60,000 a year to attempt to raise a family, pay off $150,000 in student loans' and try to send one's children to college.

The medium starting salary of a physician recruiter is $59,000. I don't think it is appropriate to be paying a health care professionl with 8 years of higher education and 4 years of residency training the same amount at a physician recruiter who may or may not have graduated from college. Obviously, both are important jobs but just from the cost of the education alone this clearly is not a just level of compensation.

Thank you for your attention to this matter. If there are any questions my email is mkucera2@cox.net.

Ian Kucera, M.D.

Submitter : Dr. Christopher Ausubon **Date:** 07/31/2006

Organization : Dr. Christopher Ausubon

Category : Physician

Issue Areas/Comments

Practice Expense

Practice Expense

Reducing reimbursement amount will adversely affect my overhead cost and negatively affect healthcare delivery to my ill patients populations. Kindly increase Physician reimbursement amount for CPT 93000 and 93701.