Submitter : **Ms. Jennifer Hokanson** **Date: 09/14/2005**

Organization : **Ms. Jennifer Hokanson**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment about the proposed CMS rule 1502-P, specifically regarding the addition of DSMT to the telehealth rule. Your document recommends that DSMT NOT be added to the proposed rule and I would like to contest this. The document states that since "teaching injectable drugs" cannot be done over the phone, DSMT is therefore not eligible to be included in this proposed rule. What is not noted in the document, however, is the importance of between-visit communication with health care professionals in order to obtain and maintain adequate diabetes control for our patients. Taking insulin requires a lot more information and review than simply learning how in inject the shot itself. Things like where to inject, how to store insulin and how much to take are frequent questions we receive from patients over the phone. Sometimes these phone calls can take 20 mintues in order to review these important issues with patients. Additionally, patients also have many difficulties using their glucose testing supplies and frequently call us regarding this, as well. Under the current role, these services are not eligible for reimbursement but should be. Please reconsider adding DSMT to the telehealth bill so health care professionals can receive reimbursement for these important services.

Submitter : **Mr. Brian Pike** **Date: 09/14/2005**

Organization : **Mednet Healthcare Technologies, Inc.**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

"Please see Attachment"

CMS-1502-P-1001-Attach-1.PDF

mednet

HEALTHCARE TECHNOLOGIES INC.

September 14th, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
PO Box 8017
Baltimore MD, 21244-8017

Mednet Healthcare Technologies, Inc. is a leading provider of Remote Cardiac Monitoring services for thousands of Medicare beneficiaries each year, mainly Holter, Cardiac Event and Pacemaker monitoring.

I am writing with regard to the 2006 Proposed Physician Fee Schedule Rule that was published in the August 8, 2005 Federal Register. Under the Proposed Rule, there are a number of CPT codes related to cardiac monitoring services which would suffer drastic payment reductions, including some cuts of up to 90%, and I encourage CMS to stop implementation of the new RVUs applied to these codes until a better assessment of their impact could be completed. The affected codes include the codes for Holter monitoring, cardiac event monitoring, pacemaker monitoring and INR monitoring.

In reviewing these decreased RVUs, CMS should be mindful of the following points:

1. Cardiac rhythm abnormalities impact millions of patients each year, resulting in over a million hospitals annual admissions and an even greater number of emergency room visits.
2. Cardiac monitoring services are a critical measure in the prevention of serious cardiac conditions and allow doctors to treat a patient before his or her illness progresses to a stage requiring hospitalization or surgery.
3. Cardiac physicians rely heavily upon Independent Diagnostic Testing Facilities ("IDTF") to provide cardiac monitoring services (and other related services) to their patients. In fact, for some services, IDTFs are responsible for a substantial portion of the procedures performed on patients.
4. Due to the constant nature of cardiac monitoring, IDTFs must operate on a 24 hours a day, 7 days a week basis and maintain a complex infrastructure in order to accurately monitor patients.
5. The decreased payment rates currently proposed under the Rule will single-handedly drive IDTFs providing cardiac monitoring out of business, resulting in reduced accessibility of these important services for beneficiaries and increasing overall Medicare costs by hindering a physician's ability to stabilize and treat cardiac conditions before they require expensive surgeries and hospitalization.

Thank you for considering my comments.

Sincerely,

Brian Pike
VP, Sales & Marketing
(P) 800-606-5511 x 520
bpike@mednethealth.net

{D0076568.DOC / 1}

Submitter : **Lynn Woolsey** **Date: 09/14/2005**

Organization : **U.S. House of Representatives**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Administrator McClellan:

I am writing in regard to the proposed rule change about Medicare physician reimbursement payments, and specifically the payment locality designation for Sonoma County, California.

As you know from prior correspondence, my constituents feel Sonoma County has been arbitrarily assigned to a locality that does not realistically and adequately reflect its demographics and costs. Since 1998, physicians? groups have collapsed, the Health Plan of the Redwoods has filed for bankruptcy and scores of doctors have left the county. Low reimbursement rates are the driving factor behind all of these problems. Sonoma County?s reimbursement rates must be increased.

That?s why I am pleased to see that CMS has proposed a rule to create a separate payment locality for Sonoma County. Without a change in the reimbursement rates for Sonoma County doctors, I fear that they will be forced to stop seeing Medicare patients all together. Sonoma County, immediately north of Marin County, is growing and has related growth in the cost of living. It is my hope that by creating a separate, and higher, payment locality, physicians in Sonoma will be able to give care to those who need it most, without incurring unnecessary costs and net losses. Reimbursement rate imbalances are jeopardizing both the quality of and the access to health care, and this problem will be replicated nationwide if no changes are made.

While I have supported statewide solutions to this problem in the past, the creation of separate payment localities for Sonoma and Santa Cruz is a good first step to ensuring equity in Medicare physician reimbursements across California and the rest of the nation. I fully support the creation of a separate geographic payment locality for Sonoma County and I hope the proposed rule change is made.

Sincerely,

Lynn C. Woolsey
Member of Congress

Submitter : **Dr. Robert Strickland** **Date: 09/14/2005**

Organization : **Wake Forest University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

For most of the 23 years of my medical/anesthesiology career I have been in academic, teaching centers. I have noted continued and arbitrary restrictions on Medicare billing practices that are resulting in difficulty in recruiting and retaining the best individuals of our specialty. Therefore, I feel that the current 50% billing restrictions should be lifted. Surgeons can supervise 2 concomitant cases and bill 100% for each. Anesthesiologists in academic should be given the same privilege. Also, the Medicare anesthesia conversion factor unfairly limits reimbursement and is drastically lower than commercial rates.

Both of these CMS/Medicare imposed restrictions have in the past and will in the future result in the loss of our specialty's brightest and best as they go into private practice. I request appropriate revisions to these CMS/Medicare policies.

Thank you,
Robert A. Strickland, M.D.
Department of Anesthesiology
Wake Forest University School of Medicine

Submitter : **Dr. James O'Malley** **Date: 09/14/2005**

Organization : **Dr. James O'Malley**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support your proposal to create a new payment locality for Sonoma County. By doing so, you will help ensure the viability of physician practices in the county, and will improve access to care of Medicare beneficiaties.

Sincerely,
James R. O'Malley, M.D.

Submitter : Noreen Oltman **Date:** 09/14/2005

Organization : Noreen Oltman

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I fully support your propasal to change Sonoma Countys payment locality.It would help Sonoma County physicians improve the quality and care of all Medicare beneficiaries. This has been long overdue. Thank you for this opportunity to make a comment on this important issue.

Submitter : **Mr. Charlie Verutti** **Date: 09/15/2005**

Organization : **personal**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I feel that this reimbursement issue is huge for our community. I employ many physical therapists and occupational therapists. They cannot afford to live here and practice their profession. They can commute for 25 minutes and generate much more income. Does this make sense? I think not. Please change this rural standing. Thank you, Charlie Verutti, PT

Submitter : Ms. Kerry Verutti **Date:** 09/15/2005

Organization : none

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am in favor of raising medicare rates for Santa Cruz county. It will help us retain quality physicians and support staff.

Submitter : Mrs. GAIL O'LEARY **Date:** 09/15/2005

Organization : Mrs. GAIL O'LEARY

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

WE NEED DOCTORS BADLY IN SONOMA COUNTY. TOO MANY HAVE LEFT OR NO LONGER ACCEPT MEDICAID OR MEDICARE. PLEASE PAY THEM MORE THAN THE MEAGER FEES THEY CURRENTLY RECEIVE. IT'S A MATTER OF LIFE OR DEATH FOR MANY.

Submitter : **Mr. Don Harris** **Date: 09/15/2005**

Organization : **Mr. Don Harris**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Date: 9/15/05

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

I fully support your proposal to change Sonoma County?s payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Don Harris
122 Calistoga Rd, #327
Santa Rosa, CA 95409

Submitter : Dr. WALT MAACK **Date:** 09/15/2005

Organization : HEALDSBURG DISTRICT HOSPITAL

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

PLEASE MAKE THIS CHANGE. EXPENSES ARE SIMILAR TO MARIN YET OUR REIMBURSEMENTS ARE TOO LOW. PLEASE SUPPORT THE CALL TO INCREASE BY 8% FOR SONOMA COUNTY.
THANK YOU.

Submitter : Dr. Roger Royster **Date:** 09/15/2005

Organization : Wake Forest University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Academic Anesthesiologists train the future anesthesiologists of this country in which there is presently a critical shortage, which in many areas of the country limit surgical cases for patients on a daily basis. Presently academic anesthesologists must take a 50% reduction in their fees from medicare when they direct 2 resident cases simultaneously. This is in contrast to academic surgeons who do not have their fees from medicare decreased when directing 2 resident surgical case simultaneously. This makes it difficult for the academic anesthesia departments of this country to recruit and retain faculty and provide adequate training with the latest educational techniques(simulation equipment) and also does not appear to be fair when compared to our surgical colleagues. Please consider changing the medicare fee schedule for academic anesthesiologists to allow no reduction when directing 2 resident cases simultaneously. Thank you.

Submitter : **Miss. Nancy Randolph** **Date: 09/15/2005**

Organization : **River Park Hospital**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I am a Certified Diabetes Educator and work closely with the Registered Dietician in providing Diabetes Self-Management Training to individuals with diabetes. I agree with the proposal that DSMT could not be provided adequately by telehealth service. I also believe it would be very difficult to provide Medical Nutrition Therapy by telehealth service. There would be no opportunity to display reproduction food models that are used to depict the correct protion size important in all dietary prescriptions. Using food models and plate methods of instruction are very important to all clients, but especially those individuals who cannot read and/or have a vision impairment that prevents them from reading the very fine print of food labels. Attempting to evaluate a clients understanding of the dietary prescription, nutrient content of each food group, portion control and information provided by food labels, would be extremely difficult to assess. For these reasons I believe that it is necessary and in the best interest of all clients who need Medical Nurtition Therapy to continue to provide this service in a personal, on-site atmosphere and not include it in telehealth service.

Submitter : Dr. Jerry Clark **Date:** 09/15/2005

Organization : Wake Forest University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am requesting your support in changing the payment policy for academic anesthesiologists. As you know, there is a nationwide shortage of academic anesthesiologists and getting paid half what private practice anesthesiologists get does not help recruitment. It is for surgeons to receive full compensation when supervising residents but not anesthesiologists. Please support this change to help improve healthcare access to many.

Submitter : **Dr. James C. Crews** **Date: 09/15/2005**

Organization : **Wake Forest University Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to request your support for a change in the teaching rule which causes academic anesthesiologists to have their Medicare fees reduced by 50% for covering 2 residents simultaneously. Our department alone is losing up to $430,000 each year because of this policy. This policy is detrimental to our mission of excellence in teaching and patient care at Wake Forest University as well as other academic institutions across the state. Specific issues include:

1. It makes it more difficult to recruit and retain academic faculty for our Anesthesiology Residency program.
2. There is a nation wide shortage of academic anesthesiologists.
2. It's unfair that a surgeon receives full compensation whenever he directs 2 resident cases simultaneously while the anesthesiologist's compensation is reduced by 50% for directing 2 resident cases.

Thank you for your consideration in changing this unfair and detrimental policy.

Submitter : Dr. James Eisenach **Date:** 09/15/2005

Organization : Wake Forest University School of Medicine

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I urge you to support a change in the teaching rule which causes academic anesthesiologists to have their Medicare fees reduced by 50% for covering 2 residents simultaneously. Our department is losing $430,000 each year because of this. Problems with the current rule:

1. It makes it more difficult to recruit and retain academic faculty for our NC programs.
2. There is a nation wide shortage of academic anesthesiologists.
3. It's unfair that a surgeon receives full compensation whenever he directs 2 resident cases simultaneously while the anesthesiologist's compensation is reduced by 50% for directing 2 resident cases.

Submitter : **Dr. Neil Treister** **Date: 09/15/2005**

Organization : **CardioDynamics**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1016-Attach-1.DOC

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. A crisis in academic anesthesia practice is rapidly escalating that will significantly impact the future availability of skilled anesthesia providers.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious and detrimental impact on my Department's ability to retain skilled faculty and train new anesthesiologists. Despite assuming full responsibility for each patient's anesthesia care, managing a disproportionate percentage of severely ill or injured patients who require extensive personal involvement throughout the course of the anesthetic, bedside education of physicians in post-graduate training and a host of other academic commitments, academic faculty anesthesiologists at Washington University teaching hospitals are not permitted to receive full compensation for their clinical anesthesia services. Faculty committed to academic anesthesia and medical education are essential to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services. Unfortunately, many of my most skilled colleagues have departed for the world of private practice that consists of a healthier patient population, less stress, more favorable reimbursement and payer mix, an improved lifestyle and no academic commitments.

Under current Medicare regulations, teaching surgeons and other specialists including internists at my institution are permitted to work with residents on overlapping cases, and receive full payment for professional services, provided faculty are present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement of the global fee for each of the two procedures in which he or she is involved. A pediatrician may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

As a teaching anesthesiologist at Washington University, I am permitted to work with up to two residents on overlapping cases provided I adhere to the ASA and CMS medical direction rules for anesthesia care that requires physical presence

and active participation during all critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists working with residents on overlapping cases face a discriminatory payment penalty for each case. The global Medicare payment for each case is reduced by 50%. This penalty is not fair, illogical and unreasonable.

Correcting this inequity will establish a consistent application of Medicare's teaching payment rules across medical specialties and is an important step toward assuring that academic anesthesiologists in teaching programs are reimbursed on par with other teaching physicians.

Please end this discriminatory anesthesiology teaching payment penalty.

Yours sincerely,

John D McAllister MD

Associate Professor of Pediatrics and Anesthesiology

St. Louis Children's Hospital

Division of Pediatric Anesthesiology, 5S 31

1 Children's Place

St. Louis, Missouri

63110

Submitter : **Dr. Marsha Wakefield** **Date: 09/15/2005**

Organization : **Dr. Marsha Wakefield**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:
I am writing as an anesthesiologist at University of Alabama in Birmingham to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to academic anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers. This shortage of qualified anesthesia providers may compromise the care available to the aging of the baby boom generation in their increasing need for surgical services.

At the present time Medicare regulations allow teaching surgeons and even internists to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is neither fair nor reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the inequity of the anesthesiology teaching payment penalty.

Sincerly,
Marsha L Wakefield, MD

Submitter : **Dr. Michael Cannon** **Date: 09/15/2005**

Organization : **Wake Forest University Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

I am writing ask for your support for a change in the teaching rule which causes academic anesthesiologists to have their Medicare fees reduced by 50% for covering 2 residents simultaneously. The reasons I see for this teaching rule to be changed are:

1. It makes it more difficult to recruit and retain academic faculty for our NC academic anesthesiology programs.
2. There is a nation wide shortage of academic anesthesiologists.
3. It's extremely unfair that a surgeon receives full compensation whenever he directs 2 resident cases simultaneously while the anesthesiologist's compensation is reduced by 50% for directing 2 resident cases.

I appreciate your time and attention to this extremely important matter.

Sincerely,

Michael L. Cannon, M.D. FAAP
Assistant Professor
Department of Anesthesiology - Section on Pediatric Anesthesiology & Pediatric Critical Care
Wake Forest University Health Sciences
Winston-Salem, NC 27157

Submitter : **Dr. David Maron** **Date: 09/15/2005**

Organization : **Cardiovascular Services of America**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I disagree with the proposal to convert nuclear medicine to a designated health service, because 1) it is not possible to know if the rise in utilization of nuclear medicine services is due to overuse, and 2) it will reduce quality of care to patients, including the timeliness of diagnosis and initiation of therapy.
It is premature to restrict self-referral without the knowledge that self-referral is primarily responsible for the growth in imaging services. No study has proven whether and to what degree imaging performed in an office setting is inappropriate. In fact, an analysis by the Lewin Group found that ?self-referral is not the primary driver of growth in imaging services. Some of the fastest-growing imaging services, such as MRI and CT scans, are primarily done by radiologists?. [Koenig L et al. Issues in the Growth of Diagnostic Imaging Services: A Case Study of Cardiac Imaging. Prepared for the American College of Cardiology. May 2005.] The average growth rate for CT from 2001-2003 was 16%, with radiology responsible for 84%. The average growth rate for MRI during this same time period was 19%, with radiology representing 65%. These results do not support the idea that restricting the ability of specialty physicians to perform and interpret imaging tests in their offices will slow growth in utilization. Before forcing physicians to divest from facilities in which they own an interest, CMS should document that testing has indeed been inappropriate.
Forces other than financial motivation may explain the rise in medical imaging. The Lewin Group found that cardiologists with on-site imaging order more imaging tests regardless of financial incentives. Two additional studies found that physicians order more imaging tests when they have access to on-site imaging equipment, even when they do not own it and have no financial incentive. [Strasser RP, Bass MJ, Brennan M. The effect of an on-site radiology facility on radiologic utilization in family practice. Journal of Family Practice 1987;24:619-623. Oguz KK, Yousen DM, Deluca T, Herskovitz EH, Beauchamp NJ. Effect of emergency department CT on neuroimaging case volume and positive scan rates. Academic Radiology 2002;9:1018-1024.]
Nuclear imaging performed and interpreted in the outpatient setting has become an integral and cost-effective aspect of high quality healthcare delivery. When cardiologists integrate in-office nuclear imaging results into treatment plans, patients receive more prompt and cost-effective care. The Lewin Group study found that the increase in office-based imaging was associated with a reduction in more costly and invasive diagnostic procedures. It is preferable to have imaging tests performed by physicians who know the patient?s medical history and make treatment decisions. Patients benefit from having their imaging performed in a setting that is comfortable and convenient, often resulting in one office visit instead of multiple visits. This is efficient not only from a patient?s point of view, but for society as a whole. An effort to restrict physician eligibility to perform and interpret tests for their patients in the most efficient and effective setting goes counter to the disease management paradigm promoted by CMS.
What is needed is not a reclassification of service, but 1) dissemination of evidence-based guidelines on the appropriate use of nuclear medicine procedures for diagnosis and treatment, and 2) measurement of the quality of the service provided. For example, ensuring that the provider is adequately trained and that the facility is accredited are appropriate ways to increase the likelihood of a procedure being performed safely for the proper indications with a high quality. Reimbursement by CMS should be site-neutral and ownership-neutral, and based on the clinical appropriateness, safety, and quality of the service provided.
Respectfully,

David J. Maron, M.D., F.A.C.C., F.A.H.A.
Chief Medical Officer

Submitter : **Mrs. Paula Stanton** **Date: 09/15/2005**

Organization : **Mrs. Paula Stanton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sonoma County is an expensive area to live in. Homes, rents, gas, and many things are expensive. Doctors can't afford to see MediCaid and MediCare patients at the low rate they are paid, and afford to run a practice, and live in this area. Their rates must be increased. We can't afford to lose anymore doctors.

Submitter : **Dr. Barbara Acosta** **Date: 09/15/2005**

Organization : **University of Miami Miller School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am an anesthesiologist at Jackson Memorial Hospital, University of Miami Miller School of Medicine. I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s payment arrangement, which applies only to anesthesiology teaching programs, is discriminatory and has had a serious detrimental impact on the ability of programs to keep skilled faculty on staff.

Current Medicare regulations state that teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced to 50%. Is our service in the OR not as critical as the surgeon?s? This penalty is not fair, it is not reasonable, and it belittles our profession.

Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Submitter : **Mrs. Jodi Zenczak** **Date: 09/15/2005**

Organization : **Social Work Intern Ombudsman/Advocate, Inc.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County is in desperate need of a change in physician payment localities. There is a current lack of physicians in our area offering to treat Medicare recipients, as the current reimbursement rates do not reflect our current cost of living. It is unaffordable for doctors to take on new Medicare patients. Considering our population consists of a large number of retirees, it is of utmost importance to change our current system. Older adults in our county, including those in long term care facilities, are the ones suffering from this antiquated payment system. Thank you for looking into reforming our current payment system. I attempt to stand up for those elder community members who cannot advocate for themselves.

Signed,

Jodi Zenczak
MSW Student Intern

Submitter : **Matthew Ockander** **Date: 09/15/2005**

Organization : **I am a Medical Student**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:
I am writing as a Medical Student who will become an anesthesiologist soon. I desire to enter the field of academic anesthesiogy as a staff attending at an anesthesiology residency however, the teaching payment issues are cause for me to reconsider my plans. I would like to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

It is my opinion that Medicare?s payment arrangement, which applies only to anesthesiology teaching programs, will deter me from entering the field of academia. I do consider myself one of the leading students at the current time as I am very much involved with the leadership of our national student association called the American Society of Anesthesiologists Medical Student Delegation.

Ultimately, if things do not change I may be forced to decide between my own financial needs or my dream to share my skills and knowlege with the future of our specialty (residents). I cannot imagine I am alone.

Please take my viewpoint to heart. I am sincere in this statement and hope to make a difference by providing student's input into this looming concern.

Please end the anesthesiology teaching payment penalty.

Thank you.

Name: Matthew Ockander
Address 6233 W. Behrend Dr. #2048 Glendale, AZ 85308

Submitter : Edward Akanine

Date: 09/15/2005

Organization : Edward Akanine

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-1024-Attach-1.DOC

Edward Akanine
4224 Mt. Taylor Dr.
Santa Rosa, CA 95404

September 14, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Edward Akanine
4224 Mt. Taylor Dr.
Santa Rosa, CA 95404

Submitter : EDWARD AKANINE **Date:** 09/15/2005

Organization : EDWARD AKANINE

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-1025-Attach-1.DOC

Edward Akanine
4224 Mt. Taylor Dr.
Santa Rosa, CA 95404

September 14, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Edward Akanine
4224 Mt. Taylor Dr.
Santa Rosa, CA 95404

Submitter : SHIRLEY BRAND

Date: 09/15/2005

Organization : SHIRLEY BRAND

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-1026-Attach-1.DOC

CMS-1502-P-1026-Attach-2.DOC

Shirley Brand
6725 Fairfield Dr.
Santa Rosa, CA 95409

September 14, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Shirley Brand
6725 Fairfield Dr.
Santa Rosa, CA 95409

Submitter : C BULLERT **Date:** 09/15/2005

Organization : C BULLERT

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-1027-Attach-1.DOC

C. Bullert
PO Box 6631
Santa Rosa, CA 95406

September 14, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

C. Bullert
PO Box 6631
Santa Rosa, CA 95406

Submitter : **Dr. Michael Olympio** **Date: 09/15/2005**

Organization : **Wake Forest University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I support a change in the teaching rule which is causing academic anesthesiologists to lose 50% reimbursement when we cover 2 residents in the care of a Medicare patient.
Reasons:
I provide the same level of quality care to those patients, and remain equally responsible for their care, as if I were doing only one at a time.
The surgeons do not have a 50% reduction when they supervise 2 cases at once.
I am present and directly involved for all critical aspects of both cases.
We have a national shortage of academic anesthesiologists, in part because their salary is far less than the opportunities in private practice.
This makes it difficult to retain and recruit quality academic teachers in medicine.
Thanks,
Dr. Olympio

Submitter : Dwight Cary **Date:** 09/16/2005

Organization : Dwight Cary

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing to urge adoption of the new higher local standard for Medicare reimbursements in Sonoma County. Our cost of living is one of the highest in the country and doctors cannot afford to live here and treat Medicare patients at the existing rural/agricultural rate. We urgently need a higher reimbursement rate to keep and attract medical providers. The new local standard would merely reflect the reality of our situation.

Submitter : Mr. Charles Siebert **Date:** 09/16/2005

Organization : Mr. Charles Siebert

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I write in support of the creation of a new Medicare payment locality for Sonoma County, California. Our county suffers from a disparity of payment when compared to Marin & Napa counties, our closest neighbors. We have the largest city in any of those counties, Santa Rosa, yet we continue to be designated 'Rural.' This is causing doctors to refuse to take new Medicare recipients, a situation which seriously impairs our ability to receive necessary healthcare coverage.

I fully support the proposal to change Sonoma County's payment locality, and thank you for the opportunity to comment on this vital issue.

Submitter : **Sherry Eisendorf** **Date: 09/16/2005**

Organization : **Sherry Eisendorf**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

We strongly urge passage of the bill in locality 99 (CMS 1502-P) in order to bring Santa Cruz up to an appropriate and proper remibursement rate. This is important so that we can retain hard working and talented professionals in this high cost area.

Submitter : **Dr. Amy Muzaffar** **Date: 09/16/2005**

Organization : **Palo Alto Medical Foundation**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I support the change that removes Santa Cruz and Sonoma Counties from California's Locality 99. It seems like the fair thing to do.
Amy Muzaffar MD

Submitter : **Mr. Dan Hollingsworth** **Date: 09/16/2005**

Organization : **Mr. Dan Hollingsworth**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

WE NEED DOCTORS. PAY THEM. SONOMA COUNTY ISN'T MISSISSIPPI OR ALABAMA.

Submitter : **Dr. Ronak Desai** **Date: 09/16/2005**

Organization : **University of Chicago Hospitals**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1034-Attach-1.DOC

Submitter : **Dr. Brian Freeman** **Date: 09/16/2005**

Organization : **University of Chicago Hospitals**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:

I am writing as an anesthesiologist at the University of Chicago Hospitals to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Sincerely,
Brian S. Freeman, M.D.
The University of Chicago Hospitals
Department of Anesthesia & Critical Care

Submitter : **Dr. Annette Lindblom** **Date: 09/16/2005**

Organization : **University of Chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

TEACHING ANESTHESIOLOGISTS, see attachment

CMS-1502-P-1036-Attach-1.DOC

Submitter : **Dr. Karen McGann** **Date: 09/16/2005**

Organization : **PAMF**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I support removing Santa Cruz and Sonoma Counties for the locality 99 designation.

Submitter : **Dr. Stewart Lustik** **Date: 09/16/2005**

Organization : **University of Rochester Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. simon adanin** **Date: 09/16/2005**

Organization : **University of Chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1502-P-1039-Attach-1.DOC

Submitter : **Dr. Edward Coleman** **Date: 09/16/2005**

Organization : **Academy of Molecular Imaging**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1502-P-1040-Attach-1.DOC

Submitter : **Dr. Jennifer Anderson** **Date: 09/16/2005**

Organization : **University of Chicago Department of Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

Sincerely,

Jennifer Anderson, M.D.
1027 S. Humphrey Ave #2N
Oak Park, IL 60304

Submitter : GENE BELL **Date:** 09/16/2005

Organization : GENE BELL

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-1042-Attach-1.DOC

Submitter : MURIEL CARLSON **Date:** 09/16/2005

Organization : MURIEL CARLSON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1043-Attach-1.DOC

Submitter : **DURALEE CLEVELAND** **Date: 09/16/2005**

Organization : **DURALEE CLEVELAND**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1044-Attach-1.DOC

Submitter : **JOSEPHINE CORNETT** **Date: 09/16/2005**

Organization : **JOSEPHINE CORNETT**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1045-Attach-1.DOC

Submitter : LOIS DEMEDUC **Date:** 09/16/2005

Organization : LOIS DEMEDUC

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1046-Attach-1.DOC

Submitter : **MARGARET DOOLITTLE** **Date: 09/16/2005**

Organization : **MARGARET DOOLITTLE**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1047-Attach-1.DOC

Submitter : MARGUERITE DOWNEY **Date:** 09/16/2005

Organization : MARGUERITE DOWNEY

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1048-Attach-1.DOC

Submitter : **ESTHER EIDSEN** **Date: 09/16/2005**

Organization : **ESTHER EIDSEN**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1049-Attach-1.DOC

Submitter : DAVE CARLSON **Date:** 09/16/2005

Organization : DAVE CARLSON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1050-Attach-1.DOC

Submitter : EDWARD EIDSEN

Date: 09/16/2005

Organization : EDWARD EIDSEN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1051-Attach-1.DOC

Submitter : GINA ESTOCK

Date: 09/16/2005

Organization : GINA ESTOCK

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1052-Attach-1.DOC

Submitter : DOROTHY GULLIXSON

Date: 09/16/2005

Organization : DOROTHY GULLIXSON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1053-Attach-1.DOC

Submitter : PEWTTI HAKALA

Date: 09/16/2005

Organization : PEWTTI HAKALA

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1054-Attach-1.DOC

Submitter : DONNIE HARRIS

Date: 09/16/2005

Organization : DONNIE HARRIS

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1055-Attach-1.DOC

Submitter : . **MARIE HARRIS** **Date: 09/16/2005**

Organization : **MARIE HARRIS**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1056-Attach-1.DOC

Submitter : Dr. William pace

Date: 09/16/2005

Organization : Denali Orthopedics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I'm writing concerning the bundling of cast materials with cast application fees. I believe that this is outrageous that medicare/medicaid expects practices to absorb the cost of materials for casting. Reimburments is already at rediculous levels. Our office's cost for casting supplies was over 12,000 dolars in 04 and much higher in 05. Our office has already considered disenrollment for medicare and caid. Further cost shifting by the CMS only makes that desion easier. I implore you to reconsider you decision.

Submitter : **HELEN HAUSER** **Date: 09/16/2005**

Organization : **HELEN HAUSER**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1058-Attach-1.DOC

Submitter : ALLAN HEMPHILL

Date: 09/16/2005

Organization : ALLAN HEMPHILL

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1059-Attach-1.DOC

Submitter : HOWARD HICKMAN **Date:** 09/16/2005

Organization : HOWARD HICKMAN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1060-Attach-1.DOC

Submitter : **BESSIE HIGGINS** **Date: 09/16/2005**

Organization : **BESSIE HIGGINS**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1062-Attach-1.DOC

Submitter : MARY HINCLINE **Date:** 09/16/2005

Organization : MARY HINCLINE

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1063-Attach-1.DOC

Submitter : DONALD HOBART **Date:** 09/16/2005

Organization : DONALD HOBART

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1064-Attach-1.DOC

Submitter : MADGE HOLLAND **Date:** 09/16/2005

Organization : MADGE HOLLAND

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1065-Attach-1.DOC

Submitter : GREG HORPOCK

Date: 09/16/2005

Organization : GREG HORPOCK

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1066-Attach-1.DOC

Submitter : EMMA HOWARD **Date:** 09/16/2005

Organization : EMMA HOWARD

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1067-Attach-1.DOC

Submitter : GRACE HOWARD

Date: 09/16/2005

Organization : GRACE HOWARD

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1068-Attach-1.DOC

Submitter : MARGARET HUNT

Date: 09/16/2005

Organization : MARGARET HUNT

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1069-Attach-1.DOC

Submitter : Mr. William Myers

Date: 09/16/2005

Organization : Mr. William Myers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCI

I SUPPORT YOUR PROPOSAL TO CREATE A NEW PAYMENT LOCALITY FOR SONOMA COUNTY. SANTA ROSA HAS BEEN DESIGNATED AS A METROPOLITAN AREA FOR QUITE SOME TIME. THE NEW RATE WOULD MORE CLOSELY MATCH THE COST TO PROVIDE THE CARE.

Submitter : **ELAINE ILDERTON** **Date: 09/16/2005**

Organization : **ELAINE ILDERTON**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1071-Attach-1.DOC

Submitter : ETHEL JANES

Date: 09/16/2005

Organization : ETHEL JANES

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1072-Attach-1.DOC

Submitter : ETHEL JANES

Organization : ETHEL JANES

Category : Individual

Date: 09/16/2005

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1073-Attach-1.DOC

Submitter : STAN JANES **Date:** 09/16/2005

Organization : STAN JANES

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1074-Attach-1.DOC

Submitter : **MARIE JEFFERS** **Date: 09/16/2005**

Organization : **MARIE JEFFERS**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1075-Attach-1.DOC

Submitter : GERALDINE JENSEN **Date:** 09/16/2005

Organization : GERALDINE JENSEN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1076-Attach-1.DOC

Submitter : **JOHN JENSEN** **Date: 09/16/2005**

Organization : **JOHN JENSEN**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1077-Attach-1.DOC

Submitter : CONNIE JOACHIM

Date: 09/16/2005

Organization : CONNIE JOACHIM

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1078-Attach-1.DOC

Submitter : HELEN JOHNSON

Date: 09/16/2005

Organization : HELEN JOHNSON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1079-Attach-1.DOC

Submitter : JUDIE JOHNSON

Date: 09/16/2005

Organization : JUDIE JOHNSON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1080-Attach-1.DOC

Submitter : LOLA JUNGKEIT

Date: 09/16/2005

Organization : LOLA JUNGKEIT

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1081-Attach-1.DOC

Submitter : HANS KATENHUSEN

Date: 09/16/2005

Organization : HANS KATENHUSEN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1082-Attach-1.DOC

Submitter : ELIOT KATZ

Date: 09/16/2005

Organization : ELIOT KATZ

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1083-Attach-1.DOC

Submitter : MAE KATZ

Date: 09/16/2005

Organization : MAE KATZ

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1084-Attach-1.DOC

Submitter : **BARBARA KAVANAUGH** **Date: 09/16/2005**

Organization : **BARBARA KAVANAUGH**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1085-Attach-1.DOC

Submitter : GABY KAY **Date:** 09/16/2005

Organization : GABY KAY

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED

CMS-1502-P-1086-Attach-1.DOC

Submitter : **Dr. navin goyal** **Date: 09/16/2005**

Organization : **University of Chicago Hospitals**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:

I am writing as an anesthesiologist at University of Chicago to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

Navin Goyal, MD, Resident at the University of Chicago Hospitals

Submitter : **Dr. Robert Schmitt** **Date: 09/16/2005**

Organization : **R. Larry Schmitt, M.D., Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a 69 year old recently retired physician. It shames and frightens me to use Medicare for my health needs. Shame to see that physicains who remain available to care for me are reimbused at 50% less than their usual fees. Fright from knowing that more and more of my fellow physicians will stop accepting Medicare patients. This is one part of the crumbling USA medical
system. Yet CMS has the opportunity to equalize the reimbursement penalties to physicians in San Diego and California. These penalties, obviously, also penalize Medicare patients.
Please take appropriate actions to repair this problem of eight years duration.
R. Larry Schmitt, M.D.

Submitter : **Dr. Alain Lartigue** **Date: 09/16/2005**

Organization : **University of Chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing as an anesthesiologist at University of Chicago to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

Alain Lartigue M.D.

Submitter : **Date: 09/16/2005**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver. I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this issue.

(Issue Identifier GPCIs)

Submitter : **Dr. Robert Weller** **Date: 09/16/2005**

Organization : **Dr. Robert Weller**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

The current payment policy for academic anesthesiologists unfairly impacts the physicians responsible for training the next generation of anesthesiologists and maintaining the high standard of care and safety presently enjoyed by Medicare recipients. The current policy reduces compensation by 50% for simultaneous coverage of 2 surgical procedures when residents are the 'in-room' provider, even though Medical Direction Standards require that the attending is present for all critical portions of the anesthetic and immediately available throughout. This reduction also occurs even if two cases overlap by only a few minutes.
There is a nationwide shortage of academic anesthesiologists and difficulty recruiting and retaining strong clinicians and teachers in academic practices. Continuing the current payment policy will continue to erode the economic viability of departments charged with the education of future leaders in medicine. At the same time, the public and the government demand, and have a right to expect, a committment to continuing education, quality care, and currency of practice from its anesthesiologists. Who will maintain and teach those standards? Finally, other specialties such as Internal Medicine and Surgery receive full compensation when supervising residents in concurrent procedures or office visits, and it is not clear why an unfair reduction of compensation is applied only to anesthesiologists.
Thank you for your consideration of my comments.

Submitter : **Dr. Jeffrey Conway** **Date: 09/16/2005**

Organization : **University of Chicago Hospitals**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan,

I am writing as a resident anesthesiologist at the University of Chicago Hospitals to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Furthermore, not correcting this penalty will likely result in an ever-increasing compensation gap between anesthesiologists in private practice and those in academic settings, making recruitment of future physician educators more difficult. Should future generations of residents receive inferior teaching due to this penalty? And should future patients be subjected to anesthesiologists with inferior training experiences? And why should anesthesiology alone, a specialty which currently has a shortage of personnel in this country, be punished?

Please end the anesthesiology teaching payment penalty.

Sincerely,

Jeffrey A. Conway, MD

Submitter : **Dr. Bruce Prager** **Date: 09/16/2005**

Organization : **Orthopedic Center of Arlington**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a practicing orthopedic surgeon the plans to decrease reimbursement for total hip and knee arthroplasties as well as fracture treatment for femur fractures goes against any common sense or decency. Medicare continues to cut reimbursements yet our costs keep going up. Tell me how I am supposed to stay in business with that business model. Have you ever had your salary decreased by your employer. No, you wouldn't stand for it. Yet, CMS continues to do this. Now CMS wants orthopedic doctors to take 5% less for these already difficult procedures. This is not some outpatient procedure. It takes skill and because of global periods these patients have to be followed at no charge for 90 days postop. Patients call up and their questions must be answered. They come to the office for followup and my overhead is greater then the reimbursement. As for the bundling of casting and splinting materials in the fracture global charge that also defies logic. These material costs also keep going up. How are we supposed to put a cast on if CMS is not going to pay for it ? Who is going to take care of Medicare patients anymore ? They will end up at the charity hospitals and wait and wait and wait.

I strongly urge CMS to reconsider and not strip anymore reimbursement cuts from orthopedic surgeons.

Submitter : **Dr. Joseph Jasper** **Date: 09/17/2005**

Organization : **Advanced Pain Medicine Physicians PLLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Dear CMS folks,

I am concerned about the future of our teaching programs in medicine, particularly anesthesiology. It seems most appropriate to permit 100% payment to each case of supervised aneshtetics administerd by residents and supervised by a single attending physician. The service delivered remains a full anesthetic service.
Attendings are present during critical aneshtetic phases such as induction, intubation and emergence as well and called to the case for any concerns.
If we do not permit this then the ability to fund training programs adequately to attract high quality attendings will suffer. In the long run our patients will suffer when the quality of teaching and resultant poorly trained physicians come into being.
Please permit 100% reimbursement for simultaneous supervision of at least two residents.

Submitter : **Dr. john chalabi** **Date: 09/17/2005**

Organization : **university of chicago Anesthesiology program**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
John Chalabi, M.D
517 LaSalle lane
Buffalo Grove, IL, 60089

Submitter : **Dr. Kenneth Freese** **Date: 09/17/2005**

Organization : **Dr. Kenneth Freese**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing as the Chairman of the Department of Anesthesiology and the Anesthesiology Residency Program Director at Nassau University Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

Sincerely,
Kenneth J. Freese, M.D.
Chairman
Department of Anesthesiology
Nassau University Medical Center
Professor of Clinical Anesthesiology
State University of New York at Stony Brook

Submitter : **Dr. John C. Eckels** **Date: 09/17/2005**

Organization : **Dr. John C. Eckels**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1097-Attach-1.DOC

Submitter : **Dr. Benjamin Antonio** **Date: 09/17/2005**

Organization : **Wake Forest University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

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I urge you to support a change to the teaching rule. The current teaching rule makes it much harder to recruit and retain academic anesthesiologists. If the anesthesiologists of the future are to continue to provide high quality care and research we must be able to continue to recruit academicians. This teaching rule discriminates against all those who are trying to provide high quality care to the sickest patients and high quality education to anesthesia residents. Surgeons are not subject to the same decrease in medicare reimbursement when supervising two residents simultaneously. Subjecting anesthesiologists to a decrease in medicare reimbursement when supervising two residents is discriminatory. It attempts to diminish the importance and necessity of the vital services only anesthesiologists can provide. This rule must be changed as this is key to ensuring that the highest quality of care is delivered and research performed.

Submitter : **Mr. Jules Resnick** **Date: 09/17/2005**

Organization : **Mr. Jules Resnick**

Category : **Individual**

Issue Areas/Comments

GENERAL

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I am a Medicare beneficiary and understand that this proposed rule will remove Santa Cruz county from the Rest of California physician payment locality designation. This is important so that physicians in my community will now receive payments from Medicare on par with counties in the San Francisco Bay Area.

I greatly appreciate your attention to this very important issue and wholeheartedly support the proposed changes that you have made.

Thank You

Submitter : **Dr. Giuditta Angelini** **Date: 09/17/2005**

Organization : **UW Madison Hospitals and Clinics**

Category : **Physician**

Issue Areas/Comments

GENERAL

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I am a teaching physician in anesthesiology at a university hospital. In an attempt to adequately train residents, I am concerned about the penalty we receive when we staff two overlapping cases. All physicians in my department has been very aggressive in maintaining close supervision during critical or key points during every procedure. However, in comparison to my surgical and internist counterparts, medicare penalizes me for managing two overlapping cases. We already have a considerable amount of time and resources that go into teaching residents. Up until now, we are given an additional penalty when providing them hands on experience in the operating room. I am wondering why medicare unfairly in my opinion targets anesthesiologists in comparison to surgical and internal medicine teaching physicians. Please consider allowing 100% of the fee for two overlapping cases. I appreciate your consideration.