

**Submitter :** Dr. Andrew Kaplan  
**Organization :** Dr. Andrew Kaplan  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

As a Mohs surgeon I am deeply concerned about the proposed rule to remove Mohs surgery from the Multiple Procedure Reduction Rule (MPRR) exemption list. This proposal represents a dramatic reversal of sixteen years of the Centers for Medicare and Medicaid Services (CMS) own determination that the Mohs codes are and should be exempt from the MPRR. I believe this proposal will negatively impact Medicare beneficiaries access to timely and quality care. In addition, application of this proposal will not likely generate significant cost savings and may paradoxically increase costs of providing care to these patients.

Currently, more than 10% of patients undergoing Mohs micrographic surgery have more than one tumor treated with Mohs on the same day. Application of the proposed rule to a second tumor treated on the same day will mean that reimbursement for the second procedure does not cover the cost of providing the service. Therefore, physicians will have difficulty affording the option of treating more than one tumor in the same patient on the same date. This will affect Medicare beneficiaries disproportionately, since the incidence of skin cancers peaks in Medicare-age patients, who are most likely to have multiple tumors. Additionally, patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors; many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma. The elimination of the MPRR exemption would mean that those patients most likely to have multiple tumors and most likely to have undesirable outcomes from their tumors will sustain delays in their treatment and additionally-increased risk for adverse outcomes, if physicians are asked to provide treatment at less than the cost of providing the service.

Although perhaps intended as a cost-saving measure, application of this rule will not likely generate significant cost savings and may paradoxically increase cost of providing care to these patients. When Mohs procedures are performed with higher-valued repairs such as flaps or grafts, application of the MPRR to the Mohs codes will result in reduced reimbursement for Mohs that doesn't cover the cost of the procedure. Likewise, for lower-valued repairs such as intermediate and complex layered closures, which are the most commonly performed repairs, reduced reimbursement will not cover the cost of the repair. The result in both scenarios will be an increase in referral of patients to other reconstructive surgeons for repair. Since most Mohs surgeons operate in low-cost office surgical suites but most plastic, oculoplastic, and head and neck surgeons operate in ambulatory surgery centers or hospitals, where the costs of reconstruction are greater, costs associated with repairs may actually increase. This is particularly true of patients treated in academic or group practice settings, where high volumes of patients are treated and where ready access to other reconstructive surgeons exists.

In light of the concerns raised above, I am requesting that CMS reconsider their plan to remove Mohs surgery from the MPRR exemption list and feel it would be appropriate to place Mohs surgery on the exemption list permanently. As this proposed change is due to take effect on January 1, 2008, the leaders of the American College of Mohs Surgery, the American Academy of Dermatology, the American Society of Dermatologic Surgeons, and the American Society for Mohs Surgery would appreciate the opportunity to meet with CMS to discuss possible solutions to the problem as soon as possible.

**Submitter :** Dr. Mary McGonagle  
**Organization :** Philadelphia Institute of Dermatology  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Angelo Petropolis  
**Organization :** Cochise Dermatology  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule. The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures. Mohs and the first repair also are distinct and separate procedures. The surgeon achieves no significant efficiencies by doing these on the same day. The Mohs procedure must be completed in its entirety before the repair is begun. This requires the surgeon to wait while the frozen tissue sections are being prepared before he can read the sections, determine if the tumor has been cleared, and then begin the repair. Repair requires re-rooming of the patient, repositioning of the patient, re-prepping, re-draping, re-anesthetizing and, in most cases, opening a new pack of sterilized surgical instruments for the repair.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year. We are concerned that the proposed rule would represent a significant reversal of CMS's own longstanding exemption of the Mohs codes from the MPRR. This change would result in increased medical costs, increased recurrences of skin cancer, and increased complications following surgery. Exemption of Mohs from the MPRR since 1991 has resulted in an evolution of skin cancer care that has had positive impact on patient outcomes and cost effectiveness. The past 16 years have seen higher cure rates, fewer complications, better functional outcomes, and movement of services out of the O.R. to the physician's office or other outpatient setting, resulting in significant cost savings.

Instead of having a skin cancer widely excised in the O.R. under general anesthesia and a skin graft placed, resulting in disfigurement, loss of function and an increased risk of complications, patients are treated by dermatologists who have acquired skills in accurate, margin-controlled excision (MOHS), with a cure rate of 96% to 99%, followed, usually on the same day, with a flap, linear repair, or graft. This has been enabled by the MPRR exemption for Mohs that has allowed full payment for Mohs and repair of the first lesion on the same day. The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file.

Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important. Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings. The reversal of this rule may encourage separation of the services of skin cancer removal and repair. The reversal would encourage referral to surgical specialists who are accustomed to using general anesthesia and the O.R. to perform their cases. This would result in a significant increase in costs, considerable inconvenience to our patients, loss of time from work, increased operative risks of general anesthesia, and postoperative complications from delay in repair of the Mohs-created surgical defect including increased risks of hospital-acquired infections. Please reconsider this issue which is critically important to dermatologists, Mohs surgeons, and the patients with skin cancer whom we serve.

**Refinement of RVUs for CY 2008  
 and Response to Public Comments  
 on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

**Submitter :**

**Date:** 12/19/2007

**Organization :**

**Category :** Physician

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Reimbursement continues to decline and expenses continue to mount. The past two years I have been almost HAPPY with a zero increase in Medicare reimbursement, even though I laid staff off to accommodate increased expenses. The planned current reduction will devastate physician offices. I will no longer see new Medicare patients in 2008 and will continue to expand my cosmetic practice, further reducing access to seniors who need dermatology care in droves.

Additionally, the deletion of the long justified exception to the 'multiple procedure reduction' for Mohs surgery is wrong and will inconvenience seniors. Physicians will simply ask seniors to return on multiple days to get treatment, circumventing the reduction modifier. Many of my patients travel 50 miles or more, and I have already printed a handout explaining why the reduction in reimbursement requires me to ask them to return again and again.

**Submitter :** Dr. Robert Willard

**Date:** 12/19/2007

**Organization :** Dermatology and Mohs Surgery Center

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Dr. Mark Duffy  
**Organization :** BayCare Clinics  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Please be advised that the procedure (balloon dacryoplasty - 68816) takes longer to do than a standard probing of a tear duct. The inappropriate under-reimbursement (especially considering the cost of the balloon) prohibits physicians from performing this procedure and will result in less patient access to state-of-the-art highly successful procedures and more hospital based extensive procedures. Please carefully consider what you are doing setting the physician fees so low. Thank you for your consideration.

**Submitter :** Dr. William Posten  
**Organization :** William Posten, MD, PA  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

As a result of these changes, Mohs surgeons will be forced to limit care, which will likely affect Medicare beneficiaries the most. Consequently, the government will wind up paying more money for these surgeries when the complications occur (recurrent and metastatic tumors).

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

\* I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

\* The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

\* CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

\* The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Dr. Juan Rosario-Collazo

**Date:** 12/19/2007

**Organization :** First Coast Dermatology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Dr. Kirk Ecklund

**Date:** 12/19/2007

**Organization :** Valley Dermatology Associates

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Mr. Kenneth Campo  
**Organization :** City of Vacaville, Calif.  
**Category :** Local Government

**Date:** 12/19/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

The City of Vacaville, CA, provides emergency medical and medical ambulance transport services to its citizens. These services are provided by our Fire Department personnel. The City is also responsible for the billing and collection of fees associated with provided such services.

We are strongly opposed to the added burden this pending rule change would impose on our firefighters. It is our experience that there are many missing signatures on the Ambulance Billing Authorization and Privacy Acknowledgment Form because, for a number of valid reasons, our firefighter/paramedics are reluctant to ask the patient or family for signature: they do not wish to incur unnecessary delays in getting the patient to the hospital; they need to get back into service as quickly as possible, and so on. As a result, this hesitation will cost our program Medicare dollars, resulting in even higher medical transport fees or reductions in other non-emergency medical services.

Thank you for the opportunity to voice our concerns over the rule change.

**Submitter :** Dr. marie carlin

**Date:** 12/19/2007

**Organization :** Dr. marie carlin

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Please do not subject Mohs surgery to the multiple surgeries rule as it will severely impact delivery of care to dermatologic patients.

**Submitter :** Dr. Darren Mollick

**Date:** 12/19/2007

**Organization :** Long Island Skin Cancer and Dermatologic Surgery

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

**Submitter :**

**Date: 12/19/2007**

**Organization :** ACMS, ASDS

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Dr. Amy Newburger

**Date:** 12/19/2007

**Organization :** dermatology Consultants of westchester PLLC

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule. The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

I am strongly opposed to the changes in the CPT codes relating to Mohs surgery and repairs.

**Submitter :** Dr. Robert Gold  
**Organization :** Eye Physicians of Central Florida  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

As pediatric ophthalmologists, we are fortunate to be able to offer our patients/families with nasolacrimal (tear) duct obstructions several excellent procedures to permanently open the blockage. I personally am glad that the new code, 68816, specific for balloon dilation of the nasolacrimal duct, has been approved and will be instituted beginning in January of 2008. This procedure is my procedure of choice in almost all probings after the age of 2 as an initial procedure and as well if an initial probing procedure has failed. The use of the balloon dilator has allowed me to have successful results without the potential complications of silicone intubation into the tear duct. The most common complication of intubation is dislodging of the tube, which in a study that I presented as a poster at a recent AAPOS (American Association of Pediatric Ophthalmology and Strabismus) meeting was 19.7%. Other complications included canalicular cheesewiring, corneal abrasion, difficulty with tube placement, post operative monitoring and a 20% rate of needing a second anesthesia for tube removal. There were no complications with the balloon dilation procedure in my study.

In general, the balloon dilation procedure is more complex and time consuming than the silicone intubation, and thus I strongly feel that the physician reimbursement should be allocated accordingly. The physician should be paid more than the reimbursement for silicone intubation and that is not reflected in the 2008 schedule. In addition, this procedure should be performed for the most part in ASCs, but the cost of the goods do not even make up for the ASC costs and thus we currently have to take these patients to hospitals for their surgery instead of the more cost effective ASCs.

Sincerely,  
Robert S. Gold, M.D.  
Pediatric Ophthalmology  
Eye Physicians of Central Florida  
Orlando, FL  
407-767-6411  
RSGEye@aol.com

**Submitter :** Mr. Chris Thorn  
**Organization :** Graves-Gilbert Clinic  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I understand the desire to reduce expenditures in Medicare and Medicaid. Some actions taken will have both good intentions and positive results. Some however will only have good intentions and adverse results. The theory behind reduced payments for multiple procedures might be sound in a facility type situation where rooming, anesthetizing, and recovery are the same for each patient regardless if one, two or three procedures are performed. However the theory breaks down when it comes to physician services. The physician has no economy of scale. The physician must invest the same amount of skill and time to each procedure. Specifically a MOHS surgeon invests significant skill and time on each lesion removal to make sure each is correct. They also invest significant skill and time for wound repair. There are no efficiencies gained each lesion is different and each wound repair is different.

The concept of multiple procedure reimbursement discounts for physician services will encourage higher costs and adversely impact patient care. This is how:

**Adverse behavior:** There are no economies of scale for a physician to do 1 or 2 procedures on a patient. Therefore the physician has no incentive for doing 2 procedures. They will lose reimbursement dollars without the ability for cost savings when performing multiple procedures. They will in effect be rewarded for performing 1 procedure per patient visit.

**Increased costs:** Since the physician is penalized by performing multiple procedures on the same day, they will not schedule multiple procedures and in effect schedule 1-a-days. This will end up costing Medicare more in facility costs since Medicare will lose out on the multiple procedure discount on the facility reimbursement. In addition it will create additional room demand on out patient surgical capacity thereby increasing demand for additional operating facilities which will add more costs to the system.

**Summary:** At the outset it was mentioned that some proposals have good intentions but adverse results. This is a good example. The original admirable intention of cost control will actually increase costs through: A. Loss of multiple procedure discount for the facility reimbursement, and B. additional demand for operating space thus requiring more surgical centers thereby increasing costs. Finally it will have an adverse impact on patient care since there will be multiple visits for a patient vs. one or two.

Please reconsider this action.

Submitter :

Date: 12/19/2007

Organization :

Category : Physician

Issue Areas/Comments

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

I strongly oppose CMS' decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Dr. Thomas Braza

**Date:** 12/19/2007

**Organization :** Dr. Thomas Braza

**Category :** Physician

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

I strongly oppose CMS' decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule. Mohs surgery is a unique procedure involving excision, laboratory, and pathology for treating skin cancers. The work involved to remove the cancer, to process the tissue, and to check for tumor-free margins under the microscope is independent for each tumor treated on the same day. In addition, this surgery is a separate procedure from the surgical repair after the cancer has been confirmed as clear cancer-free margins. With the increase in the number of skin cancers, the withdrawal of these CPT codes from the exemption list will have an adverse impact on the health of many patients, especially those with multiple skin cancers. Please review the decision to remove the codes from the exemption list.

**Submitter :** Dr. Michele Pauporte  
**Organization :** Juva Skin and Laser Center  
**Category :** Physician

**Date:** 12/19/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

\* I strongly oppose CMS decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

\* The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

\* CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

\* The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

CMS-1385-FC-121-Attach-1.PDF

December 19, 2007

TO: CMS

RE: EXEMPTION REQUEST -- 2008 Physician Fee Schedule removed the Mohs surgical codes from the Multiple Procedure Reduction Rule (MPRR) reduction list.

To whom it may concern:

As a Mohs skin cancer surgeon in New York City, I would like you to understand the negative impact that amending the current Medicare package would have on my patients, my practice and me; and in this light, I ask you to support the permanent exemption for Mohs Surgery from the Multiple Procedure Reduction Rule.

I understand that Medicare Reform is scheduled to be on the table for review. I'd like to impress upon you that the majority of my skin cancer patients (approximately 20 patients per week) are over the age of 65 and some in their 80's and 90's. The cancers are primarily on their face and can be destructive (chewing up their noses/lips/ears etc) and they can even sometimes spread to their lymph nodes if not treated by Mohs surgery. After the cancer is removed after a series of cuts, the defect sometimes the size of a half-dollar or more, usually must be reconstructed. It is safer to do the reconstruction on the same day -- and maintaining the exemption for Mohs surgery from the Multiple Procedure Reduction Rule would allow me to continue to treat my patients in this way. Otherwise, if the exemption is overturned patients will have to come back another day for repair and the tissue will get swollen and can get infected.

Please remember that these elderly patients are often using Access-A-Ride or other health services or public transportation to come in from the 5 boroughs for the day long surgery. To ask them to return the follow day or the following week would be extremely difficult from a practical standpoint for many of them -- often requiring family members (if they have any) or other older folks to escort them -- taking days off from work and exhausting everyone involved. Not to mention increasing complication risks for my patients.

For all of the above reasons, I will not be able to continue to give the care that I know is best for my patients health and well being. Please support the permanent exemption for Mohs Surgery from the Multiple Procedure Reduction Rule when you discuss this with the Senate Finance Committee.

Thank you.

Sincerely,  
Dr. Michele Pauporte

**Submitter :** Ms. Mary Madden  
**Organization :** CMSA  
**Category :** Individual

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

December 21, 2007

Centers for Medicare & Medicaid Services  
Baltimore, Maryland

Re: Docket: CMS-1385-FC - Revisions to Payment Policies Under the Physician Fee Schedule: Medicare Interim Final Rule Physician Fee Schedule 2008 related to codes 99441, 99442, 99443, 98966, 98967, 98968

To Whom it May Concern:

Thank you for this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) interim final rule regarding revisions to payment policies under the proposed 2008 Medicare Physician Fee Schedule Docket CMS-1385-FC.

I strongly support the request by CMSA to reconsider the interim payment rule on CPT codes: 99441, 99442, 99443, 98966, 98967 & 98968 from an N status to payable codes by Medicare. These codes represent assessment and management services to beneficiaries such as:

- ? Transition of care
- ? Medication reconciliation
- ? Health literacy assessment, medication knowledge, readiness to change
- ? Motivational interviewing
- ? Patient education
- ? Medical Home coordination

Professional case/care managers use proven techniques (e.g., health literacy assessment, readiness to change tool) in working with patients, families, caregivers, and fellow healthcare professionals toward measurable improvement in health status and the most efficient use of available resources to provide quality healthcare.

Failure to provide appropriate incentives and funding for these codes affects the alignment of care coordination quality between providers, especially at the various levels for transitions of care within settings, between settings, and between health states. Poor transitions of care result in poor outcomes such as incorrect treatments, medication errors, delay in diagnosis and treatment, readmissions, patient complaints, and increased health care costs

I believe that by requesting funding support for these six codes, providers will more readily integrate case/care managers in support of the care management concepts such as the Medicare Medical Home Demonstration (MMHD), pay for performance programs, and various collaborative care models, which CMS and other regulatory agencies are discussing.

I encourage CMS to adopt a payable ruling structure for these much-needed codes to ensure consistency, accountability, and improved quality of care for beneficiaries. I thank you for your consideration of these comments on this Interim Final Rule.

Sincerely,

Mary E. Madden RN BSN CCM  
mary.madden@cbw.edu

**Submitter :** Dr. Larissa Scanlan

**Date:** 12/20/2007

**Organization :** American Academy of Dermatology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I am a dermatologist and Mohs surgeon practicing in Florida. The majority of my patients are Medicare recipients who suffer disproportionately from skin cancer. Many elderly patients present with more than one skin cancer per visit. As a Mohs micrographic surgeon my primary responsibility is to ensure complete tumor clearance by surgically removing the tumor then examining the tissue under the microscope. If another cancer is near by, it only makes sense to remove it during the same visit, thereby decreasing patient wait times and physician procedure costs. Having the ability to remove multiple tumors on the same day and to ensure complete removal by microscopic examination prior to addressing surgical wound repair/reconstruction is the gold standard for skin cancer treatment because it provides the highest cure rate (approaching 99% in most cases), minimal healthy tissue destruction, saves patients time, and is most cost effective. If there is a 50% cut to Mohs reimbursement, the cost of doing multiple procedures on the same day will become cost prohibitive to all Mohs surgeons and most surgeons will begin to only treat one site per day. This is bad medicine, but good business. Please help Mohs micrographic surgeons to continue to provide top-notch care to our elderly skin cancer patients. If cost containment is a priority to Medicare, consider that it is more expensive to treat skin cancer by any other method (the average cure rate by any other methods is approximately 70%, and incomplete tumor removal results in greater tissue destruction and requires bigger and more costly reconstruction).

**Submitter :** Diana Jakobson  
**Organization :** CVS Pharmacy Corp.  
**Category :** Pharmacist

**Date:** 12/20/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

To Whom It May Concern:

Majority of authorized refills in my pharmacy--we receive via e-fax option. It's going to be really inconvenient if this option is going to be unavailable.

Sincerely,

Diana Jakobson, PharmD

CVS store 2427

**Submitter :** Dr. THI TRAN  
**Organization :** Village Dermatology & Cosmetic Surgery  
**Category :** Physician

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

SEE ATTACHED LETTER

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

SEE ATTACHED LETTER

#125

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
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. Christine Rausch  
**Organization :** The Skin Surgery Center of Virginia  
**Category :** Physician

**Date:** 12/20/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

I strongly oppose CMS' decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Dr. Christine Rausch  
**Organization :** The Skin Surgery Center of Virginia  
**Category :** Physician

**Date:** 12/20/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

I am writing this letter to make you aware of a planned change in Medicare reimbursement policy by the Centers for Medicare and Medicaid Services (CMS) that I believe will have a significant negative impact on the healthcare of U.S. citizens and potentially add unnecessary cost to the delivery of healthcare in this country.

As you are probably aware, over a million Americans per year are diagnosed with skin cancer and over the last ten years the rate of new skin cancer diagnoses is growing at what many would call epidemic proportions. Mohs micrographic surgery is a common way of treating some of these cancers and is considered the gold standard among treatments for skin cancer, allowing the physician to examine 100% of the cancer margin to insure complete removal of the cancer with loss of as little normal skin as possible. Mohs surgery is an outpatient procedure that utilizes onsite laboratory analysis of excised tissue while the patient waits for the results. The critical component of Mohs surgery includes meticulous removal and microscopic examination of the entire edge and deep margin of the cancer, in which the same physician serves as both surgeon and pathologist. The procedure is particularly valuable in the treatment of skin cancers in cosmetically or functionally important areas such as the face, neck, hands, feet and genitalia. It is also valuable for large, aggressive, or ill-defined cancers and for those that have recurred after other previous treatment. After the cancer is removed, most patients undergo subsequent reconstructive surgery by the same doctor on the same day as the cancer removal.

In 2006, CMS reviewed the American Medical Association's Current Procedural Terminology (CPT) codes 17304-17310 (Mohs micrographic surgery) and requested that new site-specific codes be developed similar to those used for other excisional surgery. The American Academy of Dermatology, the American Society for Dermatologic Surgery, and the American College of Mohs Micrographic Surgery and Cutaneous Oncology participated in last year's review of the Mohs CPT codes, and new codes were adopted (17311-17315) addressing CMS' concerns without adversely affecting the delivery of these services to patients in need.

However, as of July 1st of this year, we were notified by CMS of a planned change in payment policy that in our opinion has the potential to negatively impact the care of our patients and could add significant cost to an already stressed healthcare budget. This planned change would remove Mohs surgery from a longstanding exemption from the multiple surgery reduction rule (MSRR, indicated by CPT modifier -51). This is a departure from a longstanding exemption agreed to by CMS and virtually all private insurance carriers since 1991. The change proposed would eliminate the exemption and decrease reimbursement by 50% for either the Mohs excision or for the associated repair, and for Mohs excision of any additional cancers treated on the same day; such a decrease in reimbursement would not cover the cost of providing the service.

If this proposed change is enacted, we will no longer be able to provide the same kind of high-quality, cost-effective services for our patients in need. We will be forced to change the way we deliver care in order to cover our costs of providing this service. The following paragraphs attempt to explain the rationale behind the need to exempt Mohs surgery from the multiple surgery reduction rule and the consequences of not doing so.

In its review of the Mohs codes in 1991, CMS agreed that Mohs excisions are separate staged procedures; they will be paid separately with no multiple surgery reductions. This rule was placed in the Federal Register at that time (Federal Register, November 25, 1991, volume 56, #227, pg 59602). In 2004, the Mohs codes were added to the CPT Appendix E list of codes exempt from the -51 modifier and the multiple surgery reduction rule, to elimi

**Submitter :** Mrs. Suzanne K. Powell  
**Organization :** Professional Case Management Journal  
**Category :** Health Care Professional or Association

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

See attachment

#128

FILE:///ELECTRONIC%20COMMENTS/ELECTRONIC%20COMMENTS/E-Comments/Active%20Files/Missing%20file1.txt

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

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

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

**Submitter :**

**Date: 12/20/2007**

**Organization :**

**Category : Individual**

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I strongly oppose CMS' decision to eliminate CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule.

The unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also completely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures.

CMS has recognized the need for a Mohs exemption since 1992 but inexplicably provided no data to support removal of the exemption in the fee schedule for next year.

The incidence of skin cancer in Medicare patients is projected to rise 32 percent by 2010, according to data from the Medicare Part B Extract and Summary System (BESS) data file. Mohs surgical procedures are proven to be highly effective in treating skin cancer, with a cure rate of 95-97 percent. Mohs is the preferred treatment when excised skin cancers have grown back, a person is at high risk for recurrence of skin cancers, or the tumor is located on the head or elsewhere where preserving the maximum amount of normal skin is important.

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

**Submitter :** Mr. Dee Evans

**Date:** 12/20/2007

**Organization :** Berlin EMS

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

It is time CMS withdraws this requirement until the many questions it has raised have been addressed by CMS. Our ambulance service hangs precariously on due to continued pressures placed on our volunteers due to unrealistic expectations of CMS and your evergrowing demands. It is time to start thinking about what is the best practice for "our patients" we treat and not place undue difficulties or restrictions. Thank you!

**Submitter :** Ms. Joy Johncox  
**Organization :** Air Evac EMS Inc  
**Category :** Nurse

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I have worked in the air medical industry for approximately 10 of my over 30 years as an RN. We are a Part B 'Supplier' In the situation of a beneficiary being unable to sign (very common in our practice simply due to injury type or pre-medication) and the lack of a qualified authorized signer...It is very difficult for us to obtain receiving facility signature. To delay our crew's liftoff to obtain a face sheet is also unacceptable delay for back in service and occupies a facility helipad for too long. I would ask that you not hold to task or 'punish' the majority of ambulance providers and suppliers that conduct their business with integrity and honest claim submission for that minority of services that submit false claims for services not rendered. I would ask that you instead hold to task that minority. Even to ask for periodic review / audits of all of us to show compliance in billing practices would be more acceptable than what you are asking us to do 100% of the time to support services that we provide. Thank you for your time.

**Submitter :** Mr. Christopher Alexander  
**Organization :** Kansas City, KS Fire Department  
**Category :** Other Health Care Provider

**Date:** 12/20/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007  
Review and relief needed concerning the implementation of CMS-1385-FC.

CMS-1385-FC-132-Attach-1.DOC



John Paul Jones  
Fire Chief

**KANSAS CITY KANSAS FIRE DEPARTMENT**  
**EMERGENCY MEDICAL SERVICES DIVISION**

Fire Headquarters Building  
815 North 6<sup>th</sup> Street  
Kansas City, Kansas 66101



Office: 913-573-5550  
Fax: 913-281-3655

**December 20, 2007**

Kerry N. Weems, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1541-P  
Box 8012  
Baltimore, Maryland 21244-8012

**Re: CMS-1385-FC; Medicare Program; re: Beneficiary Signature for Ambulance Transport Services**

Dear Mr. Weems:

I am writing to you on behalf of the Kansas City, KS Fire Department. We provide emergency and non-emergency ambulance service to the 147,000 citizens of Kansas City, Kansas as well as the 5,000 citizens of Edwardsville, Kansas. We currently provide over 14,000 transports per year. Our urban demographic is approximately 40% Medicare beneficiaries.

My comments relate specifically to the section of the Final Rule entitled "Beneficiary Signature for Ambulance Transport Service". We currently have great difficulty obtaining the patient's signature when the patient is having an emergency, is in physical distress, is unconscious, has a diminished mental capacity, or suffers from some other condition that makes getting a signature impossible at the time of transport.

While the new exception for emergency ambulance transports, listed in 42 C.F.R. §424.36(b)(6), provides a little more flexibility, it will not resolve the problem in most cases. Further, we face problems with getting the patient's signature for non-emergencies as well. For our non-emergency transports, the patient is frequently suffering from a chronic or terminal condition—in fact, this may be the very reason they need an ambulance—that makes it extremely difficult to get the patient's signature, not only at the time of transport, but also after the fact. **Therefore, we ask that you expand this new exception to include both emergency and non-emergency transports.**

The Final Rule also laid out CMS' interpretation of 42 C.F.R. §424.36(b)(5). This is an exception to the patient signature requirement, which permits the entity furnishing services to the patient, in some instances, to sign on the patient's behalf. According to CMS, this exception applies only to institutional ambulance providers who bill Medicare Part A. This is a new interpretation, as the ambulance industry has relied upon previous guidance from both CMS and its Medicare contractors that indicated that this provision applied to both providers and suppliers, e.g. Section 20.1.2 of Chapter 10 of the Medicare Benefit Policy Manual. It is extremely unfair to impose a stricter requirement on ambulance suppliers than institutional ambulance services. **Therefore, we ask that you go back to your prior interpretation and make 42 C.F.R. §424.36(b)(5) applicable to both providers and suppliers.**

The Final Rule also changed 42 C.F.R. §424.36(b)(5) to require that the entity use "reasonable efforts" to obtain the signature of the patient or another authorized person before the entity could sign on the patient's behalf. In the response to comments, you also made clear that these reasonable efforts would extend over a reasonable period of time. For Medicare, ambulance coverage is always based on the patient's condition at the time of transport. As a result, the industry has always understood the patient signature requirement to be based on the time of transport, i.e., that a claim could be submitted to Medicare as long as we documented that the patient was unable to sign and that no one was able to sign for the patient at the time of transport. This view is supported by guidance issued by Medicare contractors. To require us to now chase the patient's signature for some "reasonable period" after the transport will dramatically increase the

administrative costs associated with billing for Medicare patients, at a time when Medicare already pays us less than our costs. **Therefore, we ask that, for ambulance services, "reasonable efforts" under 42 C.F.R. §424.36(b)(5) mean reasonable efforts taken at the time of transport.**

In the Final Rule, you also stated that the purpose of the patient's signature was to prove that the service being billed was actually provided to the patient. We have always believed that the purpose of the patient's signature was to effect the assignment of Medicare benefits, and to authorize us to release the patient's medical records to CMS and its contractors to determine whether payment was warranted. Thus, proving that the transport was completed is a new purpose for the signature requirement.

While we understand CMS' desire to verify that transports were actually provided before payment is made, we believe there are more effective means of verifying that the transport was completed. Nearly all covered ambulance transports will be to or from a medical facility. These facilities must keep records as to how the patient arrived or was discharged. Thus, in the event it becomes necessary to prove an ambulance transport was provided, CMS could request the records of the medical facility. Also, since the overwhelming majority of claims are submitted electronically, the patient is not signing the actual claim form anyway. Instead, they are signing a separate piece of paper.

We are grateful that you recognize the need for relief from the patient signature requirement in certain instances. **However, to provide meaningful relief, we would ask you to eliminate the patient signature requirement entirely for ambulance services submitted using electronic claims.**

Finally, to comply with all these changes we will need to retrain all of our crew members, billing staff and other personnel. We will also need to develop new forms and educate the medical facilities we work with (both on the new exception for emergency and on the new interpretation for non-emergencies). In addition to being very costly, this training will take time. The January 1, 2008 effective date will not give us nearly enough time to retrain all of our personnel to comply with the new requirement. **For this reason, we urge you to delay implementation for a few months, in order to give ambulance services like ours the time to make these needed changes.**

Thank you for your consideration of these comments.

Sincerely,

Christopher W. Alexander  
EMS Director  
Kansas City, KS Fire Department

**Submitter :** Mr. Michael Markilinski

**Date:** 12/20/2007

**Organization :** Ford City Hose Co. #1 Ambulance Service

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

CMS should withdraw this regulation until the impact of any change from the current regulations can be fully evaluated. CMS needs to review the many questions that have arisen since publication of the final regs before republishing any changes to the current signature regulations. These new regulations place an ADDITIONAL burden on our organization and our personnel. CMS has not even provided instructions to the carriers as to how the regulations should be applied.

**Submitter :** Mr. John McArdle  
**Organization :** Nesquehoning Ambulance Corp  
**Category :** Other Health Care Provider

**Date:** 12/20/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

I think this bill needs more thought and should not be aproved. I believe the burdens this final rule will place on our Volunteer BLS Ambulance and our personnel is another way of cutting costs and creating hardship and lessoning our care time in an already burden proffession. Try creating a bill that will provide more ambulance services insead of woring about people signing for emegency services.

**Submitter :** Mrs. Shawn Rueff

**Date:** 12/20/2007

**Organization :** Mrs. Shawn Rueff

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

We believe that this will put extreme hardships on ambulance services during the "exchange" of a patient. There is a lot of responsibility on the scene of an accident. This will increase the responsibility of ambulance crews to obtain signatures rather than care for the patient. We believe that CMS should withdraw this regulation until the impact of any change from the current regulations can be fully evaluated. We encourage CMS to review the many questions that have arisen since publication of the final regulations before re-publishing any changes to the current signature regulations.

**CMS-1385-FC-136**

**Submitter :** Mr. David Morando  
**Organization :** Johnson County Med-Act  
**Category :** Other Health Care Professional

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-FC-136-Attach-1.PDF



# MED-ACT

DEPARTMENT OF EMERGENCY MEDICAL SERVICES

December 20, 2007

Kerry N. Weems, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1541-P  
Box 8012  
Baltimore, Maryland 21244-8012

**Re: CMS-1385-FC; Medicare Program; re: Beneficiary Signature for Ambulance Transport Services**

Dear Mr. Weems:

I am writing to you on behalf of Johnson County MED-ACT. We are a tax supported, county EMS agency operating in Johnson County Kansas. We serve 500,000 citizens within a 476 square mile area. We respond to all the 911 emergency calls and all the critical care transports from county Hospitals. In 2006 we transported approximately 20,000 patients, largely from 911 emergency events.

My comments relate specifically to the section of the Final Rule entitled "Beneficiary Signature for Ambulance Transport Service". We currently have great difficulty obtaining the patient's signature when the patient is having an emergency, is in physical distress, is unconscious, has a diminished mental capacity, or suffers from some other condition that makes getting a signature impossible at the time of transport.

While the new exception for emergency ambulance transports, listed in 42 C.F.R. §424.36(b)(6), provides a little more flexibility, it will not resolve the problem in most cases. Further, we face problems with getting the patient's signature for non-emergencies as well. For our non-emergency transports, the patient is frequently suffering from a chronic or terminal condition—in fact, this may be the very reason they need an ambulance—that makes it extremely difficult to get the patient's signature, not only at the time of transport, but also after the fact. **Therefore, we ask that you expand this new exception to include both emergency and non-emergency transports.**

The Final Rule also laid out CMS' interpretation of 42 C.F.R. §424.36(b)(5). This is an exception to the patient signature requirement, which permits the entity furnishing services to the patient, in some instances, to sign on the patient's behalf. According to CMS, this exception applies only to institutional ambulance providers who bill Medicare Part A. This is a new interpretation, as the ambulance industry has relied upon previous guidance from both CMS and its Medicare contractors that indicated that this provision applied to both providers and suppliers, e.g. Section 20.1.2 of Chapter 10 of the Medicare Benefit Policy Manual. It is extremely unfair to impose a stricter requirement on ambulance suppliers than institutional ambulance services. **Therefore, we ask that you go back to your prior interpretation and make 42 C.F.R. §424.36(b)(5) applicable to both providers and suppliers.**

**Submitter :** Mr. Raymond Florida

**Date:** 12/20/2007

**Organization :** Regional EMS

**Category :** Health Care Industry

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

We believe that CMS should withdraw this regulation until the impact of any change from the current regulations can be fully evaluated. We encourage CMS to review the many questions that have arisen since publication of the final regulations before re-publishing any changes to the current signature regulations for the ambulance industry. It will be an unnecessary hardship on the ambulance industry if the final regulations as written are implemented. Thank you for allowing this comment forum. Sincerely Raymond Florida, Executive Director Regional EMS

**Submitter :** Mr. Greg Miller  
**Organization :** City of Cleveland EMS  
**Category :** Health Care Provider/Association

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

This new rule, puts too much burden on a 911 system, and reduces the income from Medicare and when this is 75% of the income it can break a service. Also Patients are scared to call 911 for fear of a bill, its too hard for the patient to try to determine on there own if the ailment they have is covered for transport. Medics should not be put in the position of trying to decide if it is a covered problem. It opens the door for mistakes and makes the service liable for mistakes.

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

Too much burden being put on the medic, he is not able to devote all of his time to the patient and tending to the emergency. Most of his time is spent trying to explain to the patient, what is covered and what is not covered. To many denial of payments, make the patient scared to call for help, resulting in more people dying for lack of money.

**Submitter :** Mr. Victor Berg  
**Organization :** Llanerch Fire Company  
**Category :** Other Government

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

please, you should have separate standards for 911 and transport services

Victor M. Berg EMT-P  
Assistant Chief - EMS Operations  
Llanerch Volunteer Fire Company  
Havertown PA

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

This rule is making it difficult to be realistic. As of now most of our Medicare patients can not sign. This is because mostly of dementia or the patient does not understand what they are signing.

EMS, true 911 services are performing care, mostly volunteers who can not keep up with the ever changing rule requirements. Our payments are already low. If they drop more, it going to cause crisis when no one can afford to fuel their ambulances. This rule should be separate for 911 response and for profit transports.

**Submitter :** Mrs. Sheila Brown  
**Organization :** Cabot Emergency Ambulance Service, Inc.  
**Category :** Other Health Care Provider

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I am concerned that Medicare is mandating we obtain a signature at the time of ambulance transport beginning Jan. 1, 2008. First of all, the lead time for services to become compliant with such a requirement needs to be longer. EMT's on our squad are confused about when patient signatures are appropriate, when someone else's signature is appropriate, etc. We need more time for the training aspect to incorporate this rule. We are a volunteer organization and it is almost impossible to get everyone together for one training.

Furthermore, I work for a full time service in Barre, Vermont and I'm finding that the local hospital and nursing homes are not familiar with this change, thus making it confusing when picking up or delivering patient's to these locations and the ambulance crew is asking for a signature due to the pt being unable to sign for themselves or whatever reason. I also think that all Medicare recipient's should be advised of this requirement so they are well aware they will be asked to sign a form for us and they can let their caregiver's know of the requirement also. This is more involved than the HIPAA forms we sometimes are able to get signed.

There are also no boundaries or "what ifs" to describe what degree of "physical or mentally incapable" means. I've had several people ask me what degree of physically incapable? What if the patient is on a backboard? What if the patient is being examined by the doctor? Etc....the questions keep coming. There needs to be better clarification.

These are only a few reasons why more time is needed before implementing the Signature Rule requirement. Please reconsider changing the implementation date to 4 or 6 months down the road to allow everyone to become familiar with this rule.

Respectfully submitted;  
Sheila Brown, President  
Cabot Emergency Ambulance Service, Inc.

**Submitter :** Mr. David Harbour

**Date:** 12/20/2007

**Organization :** Matanusk - Susitna Borough EMS

**Category :** Local Government

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

If this is the correct docket my comment is then about the new signature rules. 1) The rule is confusing in it's instruction about what is expected. 2) Getting so many people that are not involved in the actual transport of the patient (i.e. receiving nurse) is problematic at best. It is of no interest to them to see that we get paid for the transport. This would entail a huge effort on our part to educate people to do something on our behalf when there is no obvious benefit to them to do so.

My hope would be that CMS delay enacting this rule until some very major problems could be resolved. Our service is not large and does not pay for itself, thus the loss of any revenue is problematic and could create difficulties in our patient's ability to access the health care system.

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

One of the first comments I'd like to make is that it should be easier to find the full text of dockets.

**Submitter :** Mrs. Lori Evans  
**Organization :** Southern Green Lake County Ambulance Service  
**Category :** Local Government

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Southern Green Lake County Ambulance Service  
877 N. Margaret St. P.O. Box 75  
Markesan, WI 53946-0075  
920-291-5789  
December 20, 2007

Centers for Medicare/Medicaid Services,

On January 1, 2008, a new Final Rule regarding Patient Signatures being obtained by Ambulance Services goes into effect.

With this letter we are encouraging you to withdraw this regulation until the impact of any change from the current regulations can be fully evaluated. Many questions have arisen since the publication of the final regulations and have generated much confusion. Our Medicare contractor doesn't even know how the regulations should be applied.

This ruling will place additional burdens on municipal ambulances that are already having difficulties staffing volunteer crews. The extra time it will take in the billing office will create more hours, which are paid for from local tax money. You already have regulated how much we can collect from Medicare patients, which comprise over 50% of our calls for service. These payments do not come close to covering our expenses. Thus the local taxpayers make up the difference. Now you are adding to that load?

Please withdraw this additional regulation until it can be reviewed at length. Also, when making future regulations, please consider the additional workload it will have on already strapped municipal ambulance services. A review of fees paid for service by Medicare and Medicaid would also be greatly appreciated, especially for rural services that often get put on the back burner.

Sincerely,

Lori Evans  
Secretary-Treasurer

**Submitter :** Mr. Mervin Wertz  
**Organization :** Exeter EMS & Susquehanna Valley EMS  
**Category :** Other Health Care Provider

**Date:** 12/20/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-FC-143-Attach-1.PDF

12/20/2007

Kerry N. Weems, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1541-P  
Box 8012  
Baltimore, Maryland 21244-8012

**Re: CMS-1385-FC; Medicare Program; re: Beneficiary Signature for Ambulance Transport Services**

Dear Mr. Weems:

I am writing to you on behalf of myself, a full-time EMS provider since 1976 having worked in emergency and non-emergency settings in Pennsylvania and California for Non-profit, For Profit, Third Service City/County Government, Volunteer EMS Squads, and the Fire Service.

The actions being taken by implementation of **CMS-1385-FC** described specifically below will again place additional undue fiscal hardship for EMS Services, who are forced to maintain a **poverty level pay scale** for most of its providers. The vast majority of EMS providers work multiple jobs to get above the poverty level, some with two full-time jobs. Implementing this Final Rule will only increase the EMS Service's administrative costs and will hinder and reduce the service's cash flow.

My comments relate specifically to the section of the Final Rule entitled "Beneficiary Signature for Ambulance Transport Service". We currently have great difficulty obtaining the patient's signature when the patient is having an emergency, is in physical distress, is unconscious, has a diminished mental capacity, or suffers from some other condition that makes getting a signature impossible at the time of transport.

While the new exception for emergency ambulance transports, listed in 42 C.F.R. §424.36(b)(6), provides a little more flexibility, it will not resolve the problem in most cases. Further, we face problems with getting the patient's signature for non-emergencies as well. For our non-emergency transports, the patient is frequently suffering from a chronic or terminal condition—in fact, this may be the very reason they need an ambulance—that makes it extremely difficult to get the patient's signature, not only at the time of transport, but also after the fact. **Therefore, we ask that you expand this new exception to include both emergency and non-emergency transports.**

The Final Rule also laid out CMS' interpretation of 42 C.F.R. §424.36(b)(5). This is an exception to the patient signature requirement, which permits the entity furnishing services to the patient, in some instances, to sign on the patient's behalf. According to CMS, this exception applies only to institutional ambulance providers who bill Medicare Part A. This is a new interpretation, as the ambulance industry has relied upon previous

guidance from both CMS and its Medicare contractors that indicated that this provision applied to both providers and suppliers, e.g. Section 20.1.2 of Chapter 10 of the Medicare Benefit Policy Manual. It is extremely unfair to impose a stricter requirement on ambulance suppliers than institutional ambulance services. **Therefore, we ask that you go back to your prior interpretation and make 42 C.F.R. §424.36(b)(5) applicable to both providers and suppliers.**

The Final Rule also changed 42 C.F.R. §424.36(b)(5) to require that the entity use “reasonable efforts” to obtain the signature of the patient or another authorized person before the entity could sign on the patient’s behalf. In the response to comments, you also made clear that these reasonable efforts would extend over a reasonable period of time. For Medicare, ambulance coverage is always based on the patient’s condition at the time of transport. As a result, the industry has always understood the patient signature requirement to be based on the time of transport, i.e., that a claim could be submitted to Medicare as long as we documented that the patient was unable to sign and that no one was able to sign for the patient at the time of transport. This view is supported by guidance issued by Medicare contractors. To require us to now chase the patient’s signature for some “reasonable period” after the transport will dramatically increase the administrative costs associated with billing for Medicare patients, at a time when Medicare already pays us less than our costs. **Therefore, we ask that, for ambulance services, “reasonable efforts” under 42 C.F.R. §424.36(b)(5) mean reasonable efforts taken at the time of transport.**

In the Final Rule, you also stated that the purpose of the patient’s signature was to prove that the service being billed was actually provided to the patient. We have always believed that the purpose of the patient’s signature was to effect the assignment of Medicare benefits, and to authorize us to release the patient’s medical records to CMS and its contractors to determine whether payment was warranted. Thus, proving that the transport was completed is a new purpose for the signature requirement.

While we understand CMS’ desire to verify that transports were actually provided before payment is made, we believe there are more effective means of verifying that the transport was completed. Nearly all covered ambulance transports will be to or from a medical facility. These facilities must keep records as to how the patient arrived or was discharged. Thus, in the event it becomes necessary to prove an ambulance transport was provided, CMS could request the records of the medical facility. Also, since the overwhelming majority of claims are submitted electronically, the patient is not signing the actual claim form anyway. Instead, they are signing a separate piece of paper.

We are grateful that you recognize the need for relief from the patient signature requirement in certain instances. **However, to provide meaningful relief, we would ask you to eliminate the patient signature requirement entirely for ambulance services submitted using electronic claims.**

Finally, to comply with all these changes we will need to retrain all of our crew members, billing staff and other personnel. We will also need to develop new forms and educate

the medical facilities we work with (both on the new exception for emergency and on the new interpretation for non-emergencies). In addition to being very costly, this training will take time. The January 1, 2008 effective date will not give us nearly enough time to retrain all of our personnel to comply with the new requirement. **For this reason, we urge you to delay implementation for a few months, in order to give ambulance services like ours the time to make these needed changes.**

Thank you for your consideration of these comments.

Sincerely,

Mervin Wertz  
Paramedic  
Susquehanna Valley EMS, Lancaster County, PA  
Exeter EMS, Berks County, PA  
[mervinwertz@aol.com](mailto:mervinwertz@aol.com)  
610-779-3421

**Submitter :** Mr. Joseph Wilson

**Date:** 12/20/2007

**Organization :** Eureka Volunteer Fire & Ambulance Company, Inc.

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

I feel that the requirements outlined put an extreme burden on EMS services and potentially jeopardize patient care just in order to obtain a signature. You are creating more paperwork than is needed. By making it more difficult, you also drive away one of the most important assets of EMS - the volunteers. You are also creating a difficult situation in determining who can sign, when to sign, what to sign. Shouldn't patient care come first?

I implore you to relax this rule and use a common sense approach. If you feel ambulance services are being abused for claims, don't penalize the ambulance service that gets called - penalize the patient.

**Submitter :** Mrs. Teri Hively

**Date:** 12/21/2007

**Organization :** Balaton EMS

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Make the requirements harder for ambulance personal, we are losing EMTS daily all across the country, alot of the runs we give up our time as volunteers to go on, are people that are not able to sign, lets think about this, we don't haul them in for the fun of it, we all have lives also. Maybe you want to give up family events and then try to get signatures out of someone who can't sign and they most often don't have someone with them who could. Or maybe we should just refuse to transport if we can't get the signature, that would work well, we can't transport cause you can't sign, so we won't get paid. Those who make these rules should come and be a volunteer EMT

**Submitter :** Raymond Barth  
**Organization :** Susquehanna Township EMS, Inc.  
**Category :** Other Health Care Provider

**Date:** 12/21/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Nationwide EMS is suffering from a lack of resources to meet the demands placed upon us. One of the things that causes really significant delays resulting in a lack of available resources is the time spent between when we get a patient to the hospital and we are able to get back on the street. In my service that time averages over 30 minutes and we aren't in a hard-hit area. Please don't add to that burden by asking the emergency providers to have to track down a certified signature that we actually took the patient to the facility. We're already buried in documentation of each and every trip.

I think a better solution lies in giving us some choices. Right now, every person that calls 911 has a right, under current state and federal regulations, to a trip to the emergency department - no matter if that is the best solution to their medical crisis. We are not permitted to treat and release if appropriate if the patient wants to go. We are also not permitted to take that patient to any other type of facility. EMS should be restructured at the national level to allow us to plug some of the holes in the public health continuum by alternatives.

Until that happens, don't continue to overload us with new requirements and mandates. Medicare, Medicaid and most major insurers already reimburse us significantly less than what it costs to provide the service. All this regulation will do is make our job more costly, both in getting the extra documentation then in processing and reprocessing the claims.

**Submitter :** Mr. Clinton Randolph  
**Organization :** Liberty Ambulance Service  
**Category :** Other Health Care Provider

**Date:** 12/21/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

This comment concerns the signature requirements for EMS and ambulance services effective January 1, 2008. These are onerous requirements which will lengthen the time we spend in facilities after dropoff securing signatures from personnel. Many personnel have already said they will refuse to sign anything and we are powerless to make them. These signatures will not assure anything. The requirement apparently is to give the CMS a feeling that these are legitimate transports. The legitimacy can be verified by the presence on the person's account of hospital or other facility charges, or looking at the facility where we picked up the patient. This is tantamount to the PCS requirement which is nothing more than a "hoop" we have to jump through but is meaningless in its content. These "hoops" need to be done away with and more should not be created. Many times persons are not able to sign and it is going to be impossible to get family of staff signatures.

**Submitter :** Mrs. Jane Giffin

**Date:** 12/21/2007

**Organization :** Huron Valley Ambulance

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

I believe that the new signature rule for ambulance providers to obtain contemporaneous signatures for ambulance transports is going to make it more difficult for us to get payments on transports we are currently doing. It is going to cost us more money and according to the GAO report released in May 2006 ambulance services are on average under compensated by Medicare by 6%. This requirement will further reduce reimbursement through federally funded programs. Carriers have not been advised on how to appropriately apply this ruling which goes into effect in 10 days which will further complicate payments. We would ask that this rule implementation be delayed a minimum of 180 days or withdrawn. Thank you for your consideration and opportunity to comment.

**Submitter :** Mr. Robert McCaughan  
**Organization :** City of Pittsburgh - Emergency Medical Services  
**Category :** Local Government

**Date:** 12/21/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

To whom it may concern:

The actions of CMS will create additional demands upon already overburdened pre-hospital care systems (EMS) throughout the country as well as already overburdened emergency departments. The last thing any pre-hospital care professional or emergency department nurse or physician needs is to sign another form. While it may seem like an insignificant request, you need to walk in the shoes of the overburdened health care professionals you are asking to do this.

We believe that CMS should withdraw this regulation until the impact of any change from the current regulations can be fully evaluated. We encourage CMS to review the many questions that have arisen since publication of the final regulations before re-publishing any changes to the current signature regulations.

Sincerely,

Robert J. McCaughan  
Chief  
City of Pittsburgh  
Emergency Medical Services  
700 Filbert Street  
Pittsburgh, PA 15232

Office: 412-622-6932  
Fax: 412-622-6941  
Pager (EOC): 412-255-2935  
E-mail: robert.mccaughan@city.pittsburgh.pa.us

**Submitter :** Mr. Tom Patava  
**Organization :** Des Moines Fire Department  
**Category :** Local Government

**Date:** 12/21/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I am the service director for a municipal ambulance service in a mid-sized metropolitan community. Our ambulances provide 911 emergency service to nearly 14,000 requests annually. Several years ago, we established a policy to obtain patient signatures for billing purposes. We successfully obtain patient signatures approximately 70% of the time. There are a variety of legitimate reasons that signatures can not be obtained, and after attending a video conference on the proposed CMS signature requirements and reviewing the documents in the Federal Register, I believe this proposed rule places a substantial burden on our ambulance service providers and administrative staff that is not achievable.

It would seem reasonable and appropriate to obtain patient signatures, when possible. A variety of situations prevent patients from being able to sign (physically or mentally incapable, immobilized on a long back board, acuity of the situation requires prompt transfer to diagnostic testing in another area of the hospital, patient is being evaluated by staff, ambulance personnel are dispatched on another alarm). Additionally, in those situations when a patient's signature can not be obtained at the time of transport, it would require an extraordinary effort to accomplish this objective. I do not have the staff, budget, or time to identify those patients who did not provide a signature, mail them a signature form, receive the form, and forward the form to our billing agent. This requirement would also result in a tremendous delay in our billing process.

I offer that when a Medicare patient calls 911 that results in a transport to an Emergency Department, they have provided our service with an implied authorization to bill Medicare for the services that we provided during transport.

As an example of the confusion this proposal has created, I've copied the body of an email I received from one of our medics:

"I have several questions regarding the signature requirements from our patients and how you want us to handle special situations:

1. Of course there is implied consent from those that can't sign due to altered LOC that sort of thing. So that isn't really an issue.
2. What about pt's that have a c-collar and are strapped and taped to a LBB? Very difficult to sign. Can we write why they are unable to sign and that they verbally ok'd that they understand the form and agree?
3. What about those that refuse to sign? Maybe I'm reading into your email too much and if I am I apologize, but the way I understand it if they don't sign they're not responsible to pay. Is that correct? (this thought is continued in number 4 and 5)
4. Perhaps we should do like the hospitals do and require the pt to sign the form prior to treatment and transport. By being up front with our customers, because that's what they are essentially, we can in most situations ensure the form is signed and we can also run into some issues and some very upset pt's and family members/bystanders. I think our complaints against us could sky rocket.
5. If we begin asking them to sign the form up front what if they refuse to sign the form but still insist that we transport them? Do we need to get PD or some other non-fire and non-family member to sign the form as a witness?
6. People with special needs (no arms to sign, blind, deaf, language barrier, etc.), what then do we do for these people? How do I get a Spanish speaking individual who can't read the form to sign it?
7. Pt rushed off to the cath-lab, x-ray, is delivering a baby.... what do we do? Wait? This can seriously delay us at the hospitals."

The proposed signature requirement places an unnecessary burden on ambulance providers and administrative staff, and I respectfully request that you reconsider this ruling.

Tom Patava, EMS District Chief  
Des Moines, Iowa Fire Department

**Submitter :** Mrs. Lisa Kepes  
**Organization :** Camp Hill Fire Department  
**Category :** Health Care Professional or Association

**Date:** 12/21/2007

**Issue Areas/Comments**

**Refinement of RVUs for CY 2008  
and Response to Public Comments  
on Interim RVUs for 2007**

**Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007**

This final rule places a great burden on our organization and personnel. We currently have great difficulty obtaining the patient's signature when the patient is having an emergency, is in physical distress, is unconscious, has a diminished mental capacity, or suffers from some other condition that makes getting a signature impossible at the time of transport.

You now want to require us to chase the patient's signature for some reasonable period after the transport. This will dramatically increase the administrative costs associated with billing for Medicare patients, at a time when Medicare already pays us less than our costs.

In the Final Rule, you also stated that the purpose of the patient's signature was to prove that the service being billed was actually provided to the patient. We have always believed that the purpose of the patient's signature was to effect the assignment of Medicare benefits, and to authorize us to release the patient's medical records to CMS and its contractors to determine whether payment was warranted. Thus, proving that the transport was completed is a new purpose for the signature requirement.

While we understand CMS desire to verify that transports were actually provided before payment is made, we believe there are more effective means of verifying that the transport was completed. Nearly all covered ambulance transports will be to or from a medical facility. These facilities must keep records as to how the patient arrived or was discharged. Thus, in the event it becomes necessary to prove an ambulance transport was provided, CMS could request the records of the medical facility. Also, since the overwhelming majority of claims are submitted electronically, the patient is not signing the actual claim form anyway. Instead, they are signing a separate piece of paper.

We are grateful that you recognize the need for relief from the patient signature requirement in certain instances. However, to provide meaningful relief, we would ask you to eliminate the patient signature requirement entirely for ambulance services submitted using electronic claims.

Finally, to comply with all these changes we will need to retrain all of our crew members. We will also need to develop new forms and educate the medical facilities we work with (both on the new exception for emergency and on the new interpretation for non-emergencies). In addition to being very costly, this training will take time. The January 1, 2008 effective date will not give us nearly enough time to retrain all of our personnel to comply with the new requirement.

For this reason, we urge you to delay implementation for a few months, in order to give ambulance services like ours the time to make these needed changes. We believe that CMS should withdraw this regulation until the impact of any change from the current regulations can be fully evaluated. We encourage CMS to review the many questions that have arisen since publication of the final regulations before re-publishing any changes to the current signature regulations.

Thank you for your consideration of these comments.

Sincerely,

Lisa A Kepes  
EMS Operations Manager  
Camp Hill Fire Department EMS

**Submitter :** Mr. Gary Cox

**Date:** 12/21/2007

**Organization :** Rocky Ford Emergency Service

**Category :** Local Government

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

The overwhelming rules and paperwork that is required to transport the sick or injured in an emergency situation is ridiculous. The Fire Department/Emergency Service have a district of 760 square miles with a staff of 23, and at times find it very difficult to meet all calls for service. I find that if the rules that are in place at the present time were adhered to we wouldn't need another set of rules.

All phase of government keep adding rules and regulation and in our business its the sick and injured that are the number one priority.

Our department always gets face sheets and other documentation on each patient that receives our services. A patient trip report on each patient is written promptly. We are not in the business of fraud.

**Submitter :** Dr. Diane Baker  
**Organization :** The Mohs Coalition  
**Category :** Health Care Professional or Association

**Date:** 12/21/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-FC-153-Attach-1.DOC

## THE MOHS COALITION

*SUBMITTED ELECTRONICALLY*

December 21, 2007

Kerry Weems  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1385-FC  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Subject: CMS-1385-FC Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for Calendar Year 2008 - Multiple Procedure Reduction Rule for Mohs Surgery

Dear Mr. Weems:

On behalf of the members of the American Academy of Dermatology Association (AADA), the American College of Mohs Surgery (ACMS), the American Society for Dermatologic Surgery (ASDS), and the American Society for Mohs Surgery (ASMS), we are very disappointed that the final 2008 Medicare physician fee schedule withdrew the Multiple Procedure Reduction Rule (MPRR) exemption for Mohs surgical procedures. As we stated in our proposed rule comments, and during in-person meetings with CMS staff, and as many patients and legislators have reiterated, the health and quality of life of our older patients with skin cancer is of paramount concern to us. Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings.

As we have said before, the unique nature of the excision and pathology components of Mohs surgery necessitates separate surgical sessions for excision of a cancer and any subsequent repair procedure performed after confirmation of clear, cancer-free margins. The work of excising, processing, and interpreting one tumor is also almost entirely independent of any work involved with treating another tumor on the same day. The efficiencies assumed in other procedures subject to the MPRR thus do not exist with respect to Mohs procedures. CMS payment policy has recognized this essential fact since 1992. Yet, without furnishing any data in support of reversing this precedent from CMS, the RUC, or the CPT panel, CMS will eliminate the exemption.

Removal of the MPRR exemption for the Mohs base codes (CPT codes 17311 and 17313) will lead to reimbursement that is far less than the cost of performing these

procedures. Specifically, the policy change will make it very difficult to offset the losses incurred in performing Mohs excision when treating older patients who, during the course of one office visit, require reconstruction of the wound following removal of the cancer or have multiple skin cancer lesions requiring treatment. Our concern is that these effects will negatively influence the current level of access to skin cancer care using Mohs surgery for the Medicare population, who is disproportionately affected by skin cancer.

Furthermore, the Part B Extract and Summary System (BESS) data file maintained by CMS shows that patient utilization of Mohs represents only 20 percent of current skin cancer treatment. Yet, patient utilization of Mohs will continue to grow as more Americans become Medicare eligible. For example, based on BESS data for 2005 (the last year available), Medicare covered a total of 2,039,479 skin cancer procedures, and as previously noted, of these procedures only 20 percent (N = 425,945) were Mohs surgery. It is also worth noting that the frequency of Mohs procedures is an excellent proxy for skin cancer because one cannot render treatment without a positive biopsy. The proposed policy change will therefore make it prohibitively costly for many Mohs surgeons to furnish Mohs surgical procedures to Medicare patients at a time when skin cancer incidence is projected to rise 32 percent by 2010.

We acknowledge efforts by CMS to prevent procedure "bundling" and to save taxpayer funds for better use through an MPRR policy. However, instead of modifying payment policy in an ad hoc manner, procedure by procedure, we believe that CMS should examine the MPRR policy in its entirety and issue an updated policy that comprehensively identifies the circumstances in which exemption is warranted

Accordingly, we respectfully request that CMS reconsider its decision and allow Mohs procedure codes to retain their historic exemption from the MPRR. Indeed, given the rising incidence of skin cancer in elderly patients, Medicare's payment policies should encourage access to Mohs surgery so they can obtain proven and effective treatment of skin cancer.

If you have questions, please feel free to contact the following staff from the Mohs Coalition:

Norma Border (AADA) at <a href="mailto:nborder@aad.org">nborder@aad.org</a> or 847-240-1814 Georgeanne Dixon (ACMS) at <a href="mailto:gdixon@mohscollege.org">gdixon@mohscollege.org</a> or 414-347-1103 Lisle Soukup Poulsen (ASDS) at <a href="mailto:lpoulsen@asds.net">lpoulsen@asds.net</a> or 847-956-9126 Novella Rodgers (ASMS) at <a href="mailto:execdir@mohssurgery.org">execdir@mohssurgery.org</a> or 714-379-6262
---

Thank you for your consideration.

Respectfully,



Diane Baker, MD,  
President, American Academy of Dermatology



David G. Brodland, M.D.  
President, American College of Mohs Surgery



Darrell S. Rigel, MD  
President, American Society for Dermatologic Surgery



Sharon Tiefenbrunn, MD,  
President, American Society for Mohs Surgery

DRB/DGB/DR/ST