

Submitter : Timothy Mazzola
Organization : Pagosa Springs Family Medicine
Category : Physician

Date: 11/20/2007

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'm shocked to learn of the 2008 Medicare Physician Fee to decrease physician pay by 10%. It's like a recurring nightmare that we have to address this issue annually, but for RURAL family docs like myself, this is unconscionable. Medicare accounts for 40% of our patient population. In an economy where all physician practice costs continue to escalate daily, it is a fiscal impossibility to simply pay RURAL family docs less. We're already at the lowest end of the physician payscale with Pediatricians and Internists. I don't have problems with discounting your fees to those procedural-based physicians that receive inordinate reimbursement for performing technically simple procedures, but to further drop the Quality of Life for those unheralded RURAL physicians already struggling CANNOT happen.

The patients we see struggle themselves, are frequently uninsured or underinsured, and frequently simply don't pay us for our services. Our practice writes off roughly 10% of bad debt annually. We obviously lose money with Medicaid which accounts for nearly 10% of our patients. Medicare accounts for 40% of our patients and we're just above breaking even with Medicare at the 2007 Fee Schedule. Frankly, there isn't any more wriggle room to recruit and pay physicians a salary close to the national average. If you insist on this unreasonable request, we'll just have to stop seeing Medicare patients. This will leave a large portion of our county's patients without healthcare, as no primary care providers in Durango take new Medicare patients and there are no other practices within 75-100 miles of ours. Please don't do that to us or those Medicare patients.

If Medicare's goal is to do away with RURAL physicians and the care of Medicare patients in rural areas, this current plan will do it. If your goal is to pay for essential medical care, please monitor the Interventional Cardiologists, Orthopedic Surgeons, Radiologists and Dermatologists more closely before applying a GLOBAL CUT that includes RURAL PRIMARY CARE PHYSICIANS.

Submitter : Dr. Marion Mazzola
Organization : Centura Hospice
Category : Hospice

Date: 11/20/2007

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I was dismayed at the news of the 2008 Physician Pay Decrease. As a Family and Hospice Physician, the majority of my patients belong to Medicare. In addition, private insurers tend to follow Medicare's lead, and drop their reimbursements as well. In hospice of Centura, we already take a large number of charity cases and have a thin margin to provide this wonderful service that so many clients and families find "invaluable." Many folks have told us they don't know what they would have done without hospice. I also work in a FP clinic in a rural town that is predominantly Medicare patients. No new Medicare patients are being accepted in La Plata County, and if this 10% cut were to pass, we would likely have to stop accepting new Medicare patients in our practice in southern Colorado, a prime retiree landing spot. This would put a major damper on their goal of retiring here in Archuleta county. Please don't do this to the struggling family docs, hospice docs and most especially Medicare patients here in Pagosa Springs.

Submitter : Jeff Frater
Organization : Case Management Society of America
Category : Nurse

Date: 11/26/2007

Issue Areas/Comments

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

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Re: Medicare Interim Final Rule Physician Fee Schedule 2008 related to codes 99441, 99442, 99443, 98966, 98967, 98968

Dear Sir:

Case Management Society of America (CMSA) appreciates 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. CMSA is the leading professional association supporting over 10,500 members providing case/care management services to patients and consumers nationally and internationally through various work environments, such as health plans, hospitals, government and employer markets.

Case/care management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's healthcare needs through communication and available resources (CMSA, 2002). As an essential part of the healthcare team, case managers routinely work directly with patients in support of medical management assessments, objectives, services, and health care coordination. The processes of health adherence assessment, education, and adherence monitoring are well within the scope of case/care management practice.

Professional case/care managers perform these responsibilities as a core function of their jobs. As licensed professionals, nurses, social workers case/care managers use proven techniques (e.g., health literacy assessment, readiness to change tool) in working with patients, caregivers, and fellow healthcare professionals toward measurable improvement in health status.

Case/care managers work collaboratively with physicians and pharmacists in coordinating and providing assessments and management services through individualized care planning and care coordination in collaboration with beneficiaries, care givers and families. In support of those interventions and services, we ask for reconsideration of 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

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 may result in poor outcomes such as incorrect treatments, medication errors, delay in diagnosis and treatment, readmissions, patient complaints, increased health care costs).

CMSA believes that by requesting funding support for these six codes, providers will more readily integrate case/care managers in support of the Medical Home concept 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.

We urge CMS to adopt a payable ruling structure for these much needed codes to ensure consistency, accountability, and improved quality of care for beneficiaries. We thank you for your consideration of these comments on this Interim Final Rule and hope we continue to work with CMS to advance Medicare beneficiaries access to high quality, state-of-the-art care. Please contact me directly at 509.570.3822 or 509.466.3443. The National Office for CMSA can be reached at 501-225-2229, if you have any questions on these comments. Thank you for your attention to these important issues.

Sincerely,

Jeff Frater, RN, BSN, CCM
President-Elect CMSA
509 570 3822
jeff_frater@hotmail.com

Submitter : Dr. Gary Markowitz
Organization : Rochester Eye Associates, P.C.
Category : Physician

Date: 11/26/2007

Issue Areas/Comments

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The proposed RVU level for 68816 for physician reimbursement is inadequate based on the level of skill and the time required.

In addition, the significantly reduced compensation for ambulatory surgery centers as opposed to hospitals is unreasonable. Furthermore, with the disposable transluminal balloon catheter and inflation device costing approximately \$300 per case, the reimbursement to the ASC is inadequate to allow ASC's to offer the procedure. This will likely force the procedures into the hospitals, ultimately costing the system more money in the long run.

Submitter : Dr. John Becker
Organization : Susquehanna Imaging Assoc.
Category : Radiologist

Date: 11/28/2007

Issue Areas/Comments

**Refinement of RVUs for CY 2008
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on Interim RVUs for 2007**

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Current proposal for 10.1% reduction in reimbursement for 2008 will undoubtedly leave this northcentral Pennsylvania community (Williamsport) without adequate radiology coverage. Given the poor insurance base in this region, escalating costs in maintaining a hospital based private practice, will force those remaining radiologists either into retirement or to areas where there is less government dependence to earn a competitive wage. Quick synopsis: 5 years ago 11 radiologists were providing services to this area, and today we have 6, of which 3 are of retirement age (>62). More than 60% of our patient population is dependent on Medical Assistance (state) or Medicare. Despite active recruitment, including use of private agencies has yet to yield us 1 radiologist. General consensus from the physician community in this area is that our elected politicians care only about Philadelphia, Pittsburgh, and Harrisburg as that is where the votes are. Bottom line is that we (northcentral PA docs) are working harder and longer, scrutinized by attorneys and watchdog groups, in a declining compensatory environment. No wonder there are so many medically underserved communities and unhappy physicians. Please reconsider before signing current proposals into law. Lord knows what the fall out will be.

Submitter : Alice Pickering, CEO

Date: 11/28/2007

Organization : Assoc Med Specialists (Coastal Cancer Center)

Category : Health Care Professional or Association

Issue Areas/Comments

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I have been in healthcare for thirty years and in cancer care for 15 years. As Chief Executive Officer of a multi-location cancer treatment center where quality patient care and access to care is our number one objective, I am writing in regard to your proposed further reimbursement cut, increasing the cut to 10.1%. Please buy down the "SGR" in lieu of paying for PQRI.

Submitter : Luanne Lange

Date: 11/29/2007

Organization : Luanne Lange

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am very concerned about the cuts that are proposed for 2008 to the Physician Fee Schedule. With the annual cuts that have been done since 2003, it is extremely hard for the physician to care for patients, help indigent patients, and make vital changes to technology or machinery and necessary updates needed to run their practices let alone pay for the employees that are needed to assist the physician. Additional staff has to be hired to verify benefits because of the confusion with different plans and to handle the ever increasing patient load. All additional staff salaries are not supported by CPT codes. Their salaries are supported by the physician fee schedule. This is not just one salary we are talking about! A physician's office requires Receptionists, Managed Care Coordinators, Medical Assistants, Lab Technicians, Phlebotomists, Nurses, Billing Dept, etc. None of these positions are billable except for the 99211, nurse visit, which pays 23.51. Next year with the proposed cuts the fee will be reduced to 21.16. This code can not be bill if an administration code is used on the same day. So, where is their salary going to come from?

Private payers follow Medicare's decisions and decrease their fee schedules accordingly. It can no longer be said that the private payers are where we "make our money".

After reading an article that discussed the generous healthcare plan provided to our government officials I do not know how this cut is justified. The government representatives do not have to suffer the consequences of their own decisions. According to the article, members of Congress are offered a "Cadillac plan which features a \$250.00 deductible and covers everything else". Why would there be any concern or interest by Congress in this crisis that is affecting elderly American citizens?

The correct parties should be held accountable, namely the pharmaceutical companies for charging so much for medications but we all know Pharma has a strong lobby in Washington. (What does happen to all the monies that are raised by American Citizens for research of drugs?) Nothing more should be done to the Medicare Fee Schedule until a fair and justified resolution can be found.

Stop making it impossible for physicians to treat patients the way they should be treated. If this continues we will no longer have enough people who would want to invest in a medical education knowing how our healthcare system is going down hill.

Please do not enforce the physician fee schedule cuts as proposed for 2008 for the sake of the future.

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Please do not enforce the physician fee schedule cuts as proposed for 2008 for the sake of the future.

Submitter : Ken Beers
Organization : Canandaigua Emergency Squad
Category : Other Health Care Provider

Date: 12/03/2007

Issue Areas/Comments

GENERAL

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Regarding the proposed rule under "N. Beneficiary Signature for Ambulance Transport Services", I submit the following comments:

The proposed rule in the case of EMERGENCY will create undue difficulty for volunteer based services that often have volunteers serving Medicare patients infrequently. To keep these volunteers trained to know who can and who cannot sign if the beneficiary cannot sign will put volunteer agencies in continuing jeopardy of not receiving payment for legitimate services rendered. Additionally, attempting to gain a signature or other authorized documentation from a hospital will place an additional burden on these already human resource taxed services.

In the case of NON-EMERGENCY transport, many patients being transported from either a hospital or skilled nursing facility are often not able to sign due to chronic physical or mental conditions. In addition, there is usually no other eligible individual is available to sign on behalf of the patient. This places the entire system at risk. Hospital overcrowding is already a problem. Imagine what will happen if hospital beds are kept full with patients who could be discharged, but the ambulance service won't transport the patient until a family representative is located and made to come to the hospital or nursing home to sign on behalf of the patient. The increased burden will only cause additional overcrowding.

I hope you will reconsider the final rule, and make changes to allow a representative of the transporting agency, OR hospital/nursing home staff, sign on behalf of the patient when the patient is not capable to sign.

Submitter : Dawn Wetherby
Organization : Dawn Wetherby
Category : Other Practitioner

Date: 12/03/2007

Issue Areas/Comments

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December 3, 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

Dear Sir:

I appreciate 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.

Case/care management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's healthcare needs through communication and available resources (CMSA, 2002). As an essential part of the healthcare team, case managers routinely work directly with patients in support of medical management assessments, objectives, services, and health care coordination. The processes of health adherence assessment, education, and adherence monitoring are well within the scope of case/care management practice.

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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 urge 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,

Dawn Wetherby, RN, CCM
821 E Hemlock ST
Kent, WA 98030