Submitter : **Mrs. Margaret Chu** **Date: 12/16/2007**

Organization : **Mrs. Margaret Chu**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#70

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE AND MEDICAID SERIVICES
FFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

#71

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

Submitter : Ms. Molly Morrow, LMSW, ACSW **Date:** 12/17/2007

Organization : Ms. Molly Morrow, LMSW, ACSW

Category : Social Worker

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

Please reconsider the proposed decisions to adversely alter the fee schedule for integral services provided by professionals throughout our country. We are working with you to provide cost-effective care that works to minimize acute hospitalizations and unnecessary ER visits. One of the BEST ways to accomplish this is to have the ability to conduct certain aspects of care telephonically to deal with the issues immediately and, many times, alleviate the need for further more costly interventions.

Submitter : **Rick Mayhew** **Date: 12/17/2007**

Organization : **South Pasadena Fire Department**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

What if a patient refuses to sign the billing form? Are we then unable to collect the fees for service? If so, this will catch on quickly and will eventually place our first responders in a very uncomfortable position.

Submitter : **Mrs. Julie Herrera** **Date: 12/17/2007**

Organization : **Mayo Clinic Jacksonville**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Please provide coding for case management services. Coordination of care and discharge planning are essential functions to a patient's well being, and decreases both hospital days and frequent readmissions where possible.

Submitter : **Mrs. Jeanne Musolf** **Date: 12/17/2007**

Organization : **CMSA**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Case Management/Care Coordination has the best interest of the patient as well as the best quality,cost-effective care at its core. Financial recogition for the performance of care coordination tasks would allow hospitals, clinics and other providers to develop their case management programs. Improved Case Management resources will further assist patients to navigate their appropriate health care system to obtain the best care for aappropriate cost. Avoidance of duplication of services is one area where costs can be minimized through the work of a case manager; enhanced communication between providers is another example. Supporting this request to CMS will be a great step in balancing quality and cost-effective health care in the USA. Jeanne Musolf, MS, RN, CCM

Submitter : **Wendy Rudder** **Date: 12/17/2007**

Organization : **PV Fire District**

Category : **Local Government**

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 proposed patient signature requrements will cause an undue hardship on local fire districts that provide ambulance services. Most of our calls are true emergencies, involving car accidents, and many times there is only one occupant in the vehicle, and unable to sign. Our district ambulance usually transfers the patient to another ambulance to be transported to the hospital, due to the long distances between our community and hospitals. The requirement to have to obtain signatures in addition to the employee of our service, will create a huge time lag in submitting bills to Medicare. Rural areas run on volunteers, not paid employees. Increasing the unnecessary paperwork load on these volunteers will serve to discourage volunteers from serving, thus creating a situation where there is no emergency service for the rural areas.

Submitter : **Mr. Charles Ansley** **Date: 12/18/2007**

Organization : **Ohio Medical Transportation, Inc dba MedFlight of**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1385-FC-77-Attach-1.DOC

#77

December 18, 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 Ohio Medical Transportation, Inc. dba MedFlight of Ohio. We are a critical care transportation company. All of our vehicles have intensive care room environments. We perform around 7,500 critical care transports per year with 8 helicopters, 5 mobile intensive care units, and 2 airplanes.

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,

/signed

Charles E. Ansley
CFO
MedFlight of Ohio

Submitter : **Mrs. Sandy Grimm** **Date: 12/18/2007**

Organization : **Mercy Medical Center**

Category : **Nurse**

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 to encourage CMS to adopt the revision in regard to payment for consultation in relation to Case Managers. As a Certified Case Manager and a RN for 27 years I see we are approaching a critical time when communication between interdisciplinary health care team is critical. Allowing physicians to bill for this important effort is paramount to the success of medication reconcilliation, and transitionig the patient from acute care to home care setting. Consider that payment to physicians can come in the beginning when the patient is at a healthier state, or at the end, when the patient is seeking acute care and racking up thousands of dollars in costs. If the physicians get a clue and use this to the patient's benefit, all of society will benefit as well. I respectfully thank you for your time and consideration of this matter. Sandy Grimm

Submitter : **Ms. Cathy Chidester** **Date: 12/18/2007**

Organization : **Los Angeles County EMS Agency**

Category : **Local Government**

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 the Acting Director of the Local Emergency Medical Services (EMS) Agency I am concerned about the requirement to obtain patient/hospital staff signature for emergency transports. This requirement may impede the delivery and availability of true EMS providers to respond to 911 calls. The majority of private provider ambulance transporta are on non-emergency basis and indeed private ambulance companies, not responding to 911 calls should be required to obtain these signatures. Ambulance companies and providers approved by the local EMS Agencies, which are listed with each State EMS Authority, should not have to meet this requirement. All 911 responses have a EMS Report Form generated with an individual sequence number on file with the local EMS Agency, validation of a 911 emergency could be obtained through the EMS Agency inwhich the call was generated. The EMS Report Form number would be thc varifier on the billing form. The EMS Report Form is utilized in nationwide.

Part of the LA County EMS Agency's responsibilities is local ambulance licensing, as such I understand the potential for abuse of the billing for emergency calls. I would suggest that the State EMS Authorities be utilized as a resource to assist CMS with criteria for "emergency medical transportation" billing.

The LA County EMS system responds to well over 650,000 911 medical calls/year. We are experiencing near crisis level of activities in our emergency departments with delays in releasing our 911 providers back into the field setting in order for them to respond to call within established and monitored time frames. The addition of signatures to verify emergency transport for the approved 911 providers will one addition to the delays in service and may have untoward consequences on patient care.

Thank you for your consideration in this matter.

Submitter : **Mr. Michael King** **Date: 12/18/2007**

Organization : **Perry Joint Fire District**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

RE: FILE CODE CMS-1385-FC

We are disappointed in the time frame that has been established in order to implement these changes in our billing process. Having only 14 days to effectively place this procedure into effect is unacceptable. Being as the Perry Joint Fire District only bills non-residents, we are taken aback by the new procedures indicated by our billing department s memo explaining the new requirements. The EMS providers of our department are more concerned with patient care than collecting signatures for payment. The transportation of a patient to a medical receiving facility is very demanding and already stressful enough without an added dimension of hoop jumping in order to receive compensation. I do not know if the individual(s) making these demands are aware of the situation that our firefighters deal with during an EMS transport. We are dealing with people whose lives are in turmoil and they are going through some extremely difficult moments in their lives. To suggest that we ask them to read and sign paperwork so we can be compensated is cruel. At that moment, we become bill collectors and not care providers in their minds. Our firefighters should not be portrayed in that manner. I do not know if anyone will read this and be able to assist us, but take our word, we will still supply the best EMS service we always have to anyone in need. And, if it takes extra time and effort to bring the compensation to us, then so be it. Or, if we do not receive compensation due to hoop jumping , we still know we provided the best care possible to someone during the possibly worst moment(s) in their lives. Captain Michael J. King, Perry Joint Fire District 12-18-07.

Submitter : **Ms. Claire Wood** **Date: 12/18/2007**

Organization : **Ms. Claire Wood**

Category : **Nurse**

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

December 18, 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.

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).

From my professional and personal experience with the healthcare system, it is evident that patients benefit greatly from the intervention of an advocate like the case manager. As complex as our healthcare system has become, it is necessary to have someone to help with navigation of the system, particularly for those with complex needs.

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 that CMS and other regulatory agencies are discussing.

I urge CMS to adopt a payable ruling structure for these 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,

Claire A Wood, RN
65 Exeter Street
Lawrence, MA 01843-2925

Submitter : **Dr. Brent Moody** **Date: 12/18/2007**

Organization : **Dr. Brent Moody**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

I have three main areas of concern with applying a 50% reduction to Mohs Micrographic Surgery.

1. In instances where the primary Mohs code (17311 or 17313) is reduced, the associated add on codes (17312 or 17314) will be more highly valued than the primary codes. As the value of the add on codes has already been determined to reflect the fact that less work is involved in the add on code, it appears inconsistent to value the primary code below the add on code. In no other family of codes in the integumentary system does this phenomenon exist, thus making the reduction of the Mohs codes a true anomaly.
2. The application of a 50 % reduction is not appropriate given the amount of intraservice work in the Mohs codes. In my practice, at least 80% of the total work is repeated when a second Mohs procedure is performed. Therefore, reducing the value of this code by 50% would significantly undervalue the code when utilized a second time.
3. The application of a 50% reduction to either the Mohs surgery code or an associated reconstruction code will drive the value of the code below the cost of providing the service, thus limiting my ability to effectively care for Medicare patients.

In light of the concerns raised above, I am requesting that CMS reconsider their plan to remove Mohs surgery from the MPRR exemption list permanently or delay implementation until a refinement in the reduction can be established that will alleviate the inconsistencies that a 50% reduction will generate.

Respectfully,

Brent R. Moody, MD, FACP, FAAD

Submitter : **Date: 12/18/2007**

Organization : **Tucson Dermatology Ltd**

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

Please reconsider the Mohs surgery exemption. This will cause a hardship for many patients who travel many miles for their skin cancer treatment. They will now have to make many trips to our office for the care they had previously been receiving.!!!!!!!!!!!

Submitter : **Dr. long quan** **Date: 12/18/2007**

Organization : **Dr. long quan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Revoking the multiple surgery exemption will greatly inconvenience the patients as doctors will only do one lesion at a time. Many of my patients have mutiple large lesions. Also, halving the repair after Mohs surgery will give doctors less incentive to to repair defects. Most will send out to plastic surgeons who will do it under general anesthesia. This costs triple the amount it would have taken in the Mohs surgeon's office. You have to pay the hospital, the anesthesiologist, and the plastic surgeon. In the end, this will cost more!

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

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Submitter : **Dr. Keith Schulze** **Date: 12/18/2007**

Organization : **Dr. Keith Schulze**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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 multiplc 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 eomplex 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 Soeiety 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.

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

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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. Daniel Behroozan** **Date: 12/18/2007**

Organization : **Dr. Daniel Behroozan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This is unacceptable. Our patients will suffer as a result because either they will have to come back on numerous days to have the same procedure performed, or their access to this necessary procedure will be taken away altogether. Please reconsider this decision. Thank you

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 Centers for Medicare & Medicaid Services (CMS) final rule on the 2008 Physician Fee Schedule removed the Mohs surgical codes from the Multiple Procedure Reduction Rule (MPRR) reduction list. Beginning January 1, 2008, Mohs surgeons performing more than one Mohs procedure on a single day will now be subject to a 50 percent reduction in reimbursement for second and subsequent procedures performed on the same day. This includes not only additional excisions, but also pathology and repair.

Submitter : **Dr. Anthony Wong** **Date: 12/18/2007**

Organization : **Long Island Skin Cancer**

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. Garin Barth** **Date: 12/18/2007**

Organization : **West Georgia Dermatology, P.C.**

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. These constitute two separate surgeries performed at different times of the day with separate surgical trays for each procedure.

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. Steven Marcet** **Date: 12/18/2007**

Organization : **American Academy of Dermatology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a Mohs surgeon in Newnan, GA. I am the only full time Mohs surgeon in a 5 county surrounding Newnan, GA. I stronly believe this will affect hundreds of my patient if the multiple surgery reduction rule applies to Mohs surgery. Numerous of my patients that travel more than an hour have more than one skin cancer at a time. Having to return to my office for Mohs surgery would be a detriment to their health care. I am afraid many patient would hesistant to travel if I could not take care of there needs at one visit. Please do not institute this rule for my patients sake. Thank you- Steven Marcet, MD

Submitter : **Dr. Michael Swann** **Date: 12/18/2007**

Organization : **Scripps Clinic Medical Group**

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

Dear Sir or Madam,
I am a young dermatologist specializing in oncology and dermatologic surgery in Southern California. Being relatively new to the field, I have learned a great deal about the great benefits of Mohs micrographic surgery, both in benefits to patients but also in minimizing societal costs in these advanced tumors. I strongly oppose CMSs decision to eliminate CPT codes 17311 and 17313 from the cxemption list to the Multiple Procedure Reduction Rule. Mohs surgery is unique because it requires specialized training of the surgeon to play the role of 3 physicians: a dermatologist, surgeon and pathologist. 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.
This revision in fee schedule may prompt physicians to recoop costs by only operating on one tumor per day, which may not be in the hest interest of the patient. Delays in recieving Mohs may push some physicians to manage these tumors by other means, which has been shown to be less efficacious and more expensive. Mohs saves true and future expected costs, not only in limiting contact with other physicians and streamlining care, but also in limiting institutional costs (no operating room costs or anesthesia costs).
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.
I understand the CMS rules are revised to reflect physician expertise and time as well as save Medicare dollars. I believe this ruling is not only a deterrent to efficient healthcare, but may actually increase indirect costs associated with treating skin tumors. Ideally, efficient, cost-effective practices with the highest cure rates should be rewarded and encouraged. Please review and correct this and add Mohs Surgery to the exception list.

Sincerely,

Michael H. Swann, MD
Procedural Dermatology
Scripps Clinic Medical Group

Submitter : **Dr. David Smack, MD** **Date: 12/18/2007**

Organization : **Talbot Dermatology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Regarding the loss of the Multiple Surgery Reduction Rule Exemption for Mohs surgery codes, I must express to you what a hardship it is going to be for my patients and my staff. I practice Mohs surgery in a rural area and draw patients from a 200 mile radius. Most of my patients are elderly and it requires significant effort to travel to my office to have their skin cancer removed. A large number of these patients have more than one skin cancer that requires treatment and it had been our practice to try and remove all cancers in one visit. The loss of the multiple surgery reduction rule exemption means we will no longer perform this service for our patients and we are even contemplating not performing the repair on the same day. Thus, the patients will have to return to my office two separate times for each skin cancer removed. This is because I will be put out of business if we do not do this. How many businesses are you people at CMS aware of that can absorb a 50% reduction in the price of the services they provide and still conduct their business. The answer is easy..... none! On the top of that we are not talking about the manufacture of widgets, we are talking about saving people's lives, preventing permanent facial disfigurement and curing cancer. That 's right cancer!! Mohs surgery is the most effective and most efficient manner of removing basal cell and squamous cell cancers of the skin ...bar none. Sure Medicare can pay more (that is right more - general anesthesia fees, surgicenter fees, preop ekg, labs..etc.) to have a general or plastic surgeon remove a skin cancer, and that does not even include the 25 - 40% increased rate of recurrence (thus same procedure has to be performed again along with outlined attendant extra fees above). Thirty-percent of the cancers I remove in my practice are recurrences from procedures performed by plastic and general surgeons and 10% of these lesions had undergone multiple procedures prior to referral to me. You do the math!

Additionally, your proposed 50% reduction for my services is on top of another planned 2008 10% cut in medicare rates for my speciality and the penalty in rates that I already receive because I practice in a rural area with a supposedly lower cost of living.

My mentor practiced into his mid seventies. I am 45 and I am looking for another line of work. I doubt very seriously if I will practice beyond the age of 55. So, I will be retiring just when the baby-boomer demographic bubble bursts. Sure you can replace me but it took 15 years of higher education to form my skills. Good luck!

D. P. Smack, M.D., F.A.A.D.

Submitter : **Dr. Rachel Reina** **Date: 12/18/2007**

Organization : **Dr. Rachel Reina**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am opposed to the removal of Mohs' codes from the multiple surgery reduction list. This change will result in patients' not having lesions treated, the involvement of more physicians in each case, and likely, increased costs for medicare. Thank you.

Submitter : **Dr. Noah Kawika weisberg, M.D.** **Date: 12/18/2007**

Organization : **palm Beach Dermatology**

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.

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Submitter : **Dr. Joseph Gadzia** **Date: 12/18/2007**

Organization : **Independant**

Category : **Physician**

Issue Areas/Comments

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

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The Centers for Medicare & Medicaid Services (CMS) final rule on the 2008 Physician Fee Schedule removed the Mohs surgical codes from the Multiple Procedure Reduction Rule (MPRR) reduction list. Beginning January 1, 2008, Mohs surgeons performing more than one Mohs procedure on a single day will now be subject to a 50 percent reduction in reimbursement for second and subsequent procedures performed on the same day. This includes not only additional excisions, but also pathology and repair.

CMS is making it very difficult for me to continue to see medicare patients. Health care costs continue to skyrocket for my practice, but CMS continues to pay less and less for the same procedures. If cuts like this continue, i will have to opt out of the medicare reimbursement program creating and undo hardship on my medicare patients. I hope that you will reconsider this horrible policy for the sake of patients with skin cancer.

Submitter : **Dr. Jeffrey Carmel** **Date: 12/18/2007**

Organization : **Center for Dermatology**

Category : **Physician**

Issue Areas/Comments

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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.

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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. Tom Spenceri** **Date: 12/18/2007**

Organization : **Premier Dermatologic Surgery, P.A.**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

By eliminating CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule, you are downgrading the quality of care provided to Medicare patients. Mohs Surgeons will no longer be able to provide the best quality of care to Medicare patients because they would not be covering their costs. The patients will be required to make multiple visits to the physician's office when their treatment could have been completed in one visit.

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

Why would we deter Physicians from accepting Medicare when the number of patients going on Medicare is increasing?

Submitter : **Dr. Johnathon Edge** **Date: 12/18/2007**

Organization : **Dermatology & Skin Cancer Specialists, PSC**

Category : **Physician**

Issue Areas/Comments

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

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I strongly oppose the removal of CPT codes 17311 and 17313 from the multiple surgery exemption list. A significant portion of the work associated with these codes is pathology and lab work -- there exists very little efficiencies afforded with performing subsequent procedures on the same date of service. Furthermore, surgical repairs of the defects are performed in a completely separate operative session; similarly, little to no efficiencies are afforded by performing the procedure on the same date of service. If this change is allowed to stand, it will change the way that skin cancer care is practiced, resulting in longer waits, the inconvenience of going to multiple doctors over multiple days, or difficulty obtaining access to this very valuable service. When taken in combination with the greater than 10% cut that we face from Medicare, my solo practice in a small town will be rendered insolvent, forcing a change in location and consolidation with a larger provider.

Submitter : **Dr. Elizabeth Spenceri** **Date: 12/18/2007**

Organization : **Dr. Elizabeth Spenceri**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mohs surgery is a specialized procedure yeilding the highest cure rate (from 95-99%) for non-melanoma skin cancer and maximizing tissue conservation. It's considered the ideal treatment option for non-melanoma skin cancer in high risk anatomic locations such as the face, eyelid, ears, nose, lips, and scalp; skin cancers larger than 2 cm; tumors returning after prior treatment; tumors growing rapidly or occuring in immunocompromised patients; and tumors with positive margins following prior removal.

Points of concern:
1. The excision and pathology components of Mohs surgery are separate components of the same proceure, with no increase in efficiency of one component by the other. In addition, any subsequent repair procedure performed after pathologic confirmation of clear, cancer-free margins is considered separate and cannot be fully anticipated or prepared upon the initial planning of the Mohs surgery (again, no increase in efficiency for the subsequent repair).
2. 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.
3. 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. This is contrary to common sense and previous standards upheld by CMS.
4. 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. Access to care for these patients will only become a more important issue in the future.
5. The recent (2007) RUC review of these codes showed that over 80% of the work in Mohs surgery is 'intraservice', again confirming no increase in efficiency for multiple procedures. A proposed 50% reduction in second surgeries following the initial Mohs surgery would not account for the cost of performing the surgery. As such, patients will likely be limited to only one site per day with increased reliance on other providers to perform reconstruction (i.e. plastic surgeons and ENT's, many of whom perform their procedures in a hospital or ambulatory surgery center, thereby increasing the cost for the treatment) or increased use of healing without reconstruction (which may leave disfiguring results in select sites). Further concerns arise when patients who are immunocompromised such as organ transplant patients develop rapidly growing tumors and develop multiple tumors concurrently. These patients will experience delays in treatment that can increase their morbidity (and in some situations, mortality).

Withdrawal of the MPRR exemption for Mohs surgical procedures will have an adverse impact on the health of these patients without generating significant savings for CMS. I take pride in providing quality, efficient care for all my patients. If these changes are upheld, I will need to make significant changes in my practice, namely, limiting treatment to only a single Mohs surgery per patient per day. The inconvenience to my patients and their loved ones who care for and/or assist them (for emotional support and for transportation), who may need to take additional days off work and increase travel expenses for patients traveling to see me up to 2 hours away) will be devastating. Further, my concern for the added risks to their health if we need to delay Mohs surgery for multiple tumors can contribute to serious adverse consequeces in their health and function.

CMS rules and regulations inevitably affect us all, either as distant future concerns for ourselves or near future concerns for our loved ones. Please reconsider the decision to add CPT codes 17311 and 17313 to the MPRR list.

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Regarding the elimination of CPT codes 17311 and 17313 from the exemption list to the Multiple Procedure Reduction Rule (MPRR).

Submitter : **Dr. Edward Kramer** **Date: 12/19/2007**

Organization : **Dr. Edward Kramer**

Category : **Physician**

Issue Areas/Comments

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Dear CMS,

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

I am a board-certified fellow of the American Society for Mohs Surgery. I have been performing Mohs surgery for the last 20 years. All of my surgeries are done in an outpatient setting with local anesthesia avoiding hospitalizations and general anesthesia for my patients. This is the most cost-effective method available to treat skin cancer and affords my patients 99% cure rates.
The application of the 50% reduction rule will make it difficult, if not impossible to cover my expenses in offering this most valuable procedure.
I would ask the question, would any of you be able to absorb a 50% pay reduction in your salaries? This is in addition to another 10% reduction in reimbursements across the board being imposed in 2008.
This is what my grandfather would have termed "shooting oneself in the foot".
Please again, rescind this completely unfair and short-sighted ruling!!!!!!

Sincerely,

Edward M. Kramer, M.D.

Submitter : zheng qian **Date:** 12/19/2007

Organization : the vancouver clinic

Category : Physician

Issue Areas/Comments

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I strongly oppose the multiple reduction rule for Mohs surgery. Mohs surgery is the most effective and tissue sparing technique to remove the skin cancer, especially for people with multiple skin cancers on the face.
This reduction will create an access problem, especially for those with many skin cancers when Mohs is most needed, they will be forced to come back on different days to remove different cancers. It will inevitably increase the aggravation and inconvenience for these patients.
The exemption has been in effect in 1992, it has enabled dermatologists serve the population well. The original reduction rule is used to account for the reduced overhead when one surgical setup is used on the same patient, this obviously doesn't apply to the slide processing and pathology --- so the very least this should be adjusted.

Submitter : **Dr. Adrian Guevara** **Date: 12/19/2007**

Organization : **Sun City Dermatology, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Removing the Mohs codes from the multiple procedure reduction rule list will result in a tremendous disservice to patients. Now, patients with multiple cancers will be forced to wait even longer as Mohs surgeons are forced to ration our time to one lesion per visit. As it is in my geographic area, patients will drive over two hours to see me. Now instead of being able to perform multiple cancer excisions and sophisticated repairs for multiple defects, this change in reimbursement will deincentivise the extra effort that physicians like me put forth to properly care for patients. The short sighted nature of this cut will certainly come back to haunt the CMS. This is because this rule will clearly lead to the progression of basal and squamous cell carcinomas, and then more and more expensive hospital based surgeries will have to be performed with adjuvant chemotherapy and radiation therapy to follow. CMS should look closely at the work that goes into performing this expert procedure and realize that you get what you pay for in this world.

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Submitter : **Dr. Leila Ettefagh** **Date: 12/19/2007**

Organization : **Island Dermatology**

Category : **Physician**

Issue Areas/Comments

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I'd like to voice my concern regarding the removal of the Mohs surgical codes from the Multiple Procedure Reduction Rule (MPRR) reduction list. Mohs surgery is a vital tool dermatologists have to appropriately treat large/aggressive carcinomas in a tissue-sparing manner. Reducing compensation to highly trained physicians for this vital technique is unexplainable.