Submitter : Andy Esquivel
Organization : Andy Esquivel
Date: 09/26/2005
Category : Individual
Issue Areas/Comments

GENERAL

GENERAL

Andy Esquivel
979 Linda View
Healdsburg, CA 95448

MEMORANDUM

DATE: September 26, 2005

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

FROM: Andy Esquivel

Re: GPCIs

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

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

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

Submitter : **Mr. Charles Cowen** **Date: 09/26/2005**

Organization : **Retired, member of AARP**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am a senior living in Santa Rosa, Ca., a very expensive city in which to live. I have seen many of our fine physicians leave the community for lack of fair reimbursement from Medicare and other payors. It is now hard for a senior to find a physician willing to accept Medicare reimbursement, since it is lower than many other counties. There is no way Sonoma County should be considered rural or anything less than Marin, Napa and Solano counties in terms of physician reimbursement. Please help me and other seniors have quality healthcare providers in Santa Rosa.
Thanks,
CE Cowen

Submitter : **Dr. Carmen Maymi** **Date: 09/26/2005**

Organization : **Department of Veterans Affairs**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Though this does not affect my payments being a goverment employee, it will affect the whole system of anesthesia care. This will cause a shortage of future anesthesia providers right when the baby boomers and gemeration X will be requiring their services. The current trend shows an increasing number of complexities due to concurrent and severe medical problems and diseases.

Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. This includes not only the training of future anesthesiologist, but also the need to continue with research which have made significant contributions both in safety and innovations. We have come a long way from ether.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is not fair, and it is not reasonable.
Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

The shortage and windfall of this decision will affect me and possibly you in the near future as our chances increase that we would require some type of surgery. I would like to have an anesthetic to go along with the surgery.

Submitter : **Dr. Louis Du Brey**

Organization : **Dr. Louis Du Brey**

Category : **Other Practitioner**

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P
To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS?considerations for other non-physician practitioners.
In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other healthcare insurers. The number of those impacted will only increase as America?s population grows and ages. In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.
Sincerely,

Louis Du Brey AU.D.

Submitter : **Dr. Susan Bankoski Chunyk** **Date: 09/26/2005**

Organization : **Hampden Hearing Center East**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1502-P

To Whom It May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The elimination of the 'non-physician zero work pool' codes without regard for practice expense or patient care factors is short-sighted and inappropriate. CMS has not recognized nor collected data on audiological care that would justify this change to a policy that has existed for decades. This large reimbursement reduction is especially egregious in light of CMS's considerations for other non-physician practitioners.

As an audiologist in an independent private practice, I can assure you that the audiologist's responsibility extends beyond the diagnostic measurement of hearing using test equipment, and also includes interpretation of test results and explanation and counseling of patients. In fact, I have spent many hours of (uncompensated) time during my 21 years of clinical practice, reviewing and explaining to patients test results brought to me by the patients from an ear, nose and throat physician's office. The scope of practice for a professional audiologist includes not only the turning of test equipment dials, but also the professional component of counseling the patient. These services require considerable time and such time should be reimbursed fairly.

In view of this proposed policy change that results in four times greater reduction of audiologists'reimbursement than for any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. This hiatus would allow for data collection to justify or refute the current reimbursement level for our services. As you know, your proposed change would directly affect over 40 million Medicare insureds and indirectly affect other insureds whose health care insurers base reimbursement rates on Medicare rates. The number of those impacted will continue to increase as America's population grows and ages. These individual deserve to have freedom of choice in selecting the provider of their audiological care, including audiologists in private practice independent of physicians.

In light of this profound change to hearing and balance services for such a large segment of the American population, a period of study is reasonable and appropriate. A cut of this proportion would certainly impact my ability, and the ability of most of my professional audiologist colleagues, to provide the high level of care American patients deserve. Therefore, I respectfully request that CMS impose a moratorium on audiologists' reimbursement reductions in its most recent proposed physician fee schedule.

Yours truly,

Susan Bankoski Chunyk, Au.D., CCC-A
Doctor of Audiology

CMS-1502-P-1606

Submitter : **Dr. Kamal Elliot** **Date: 09/26/2005**

Organization : **Pennsylvania Academy of Audiology**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P
To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.
Sincerely,

Dr. Kamal A. Elliot, Au.D.
Doctor of Audiology

Submitter : **Dr. Charles Burkett** **Date: 09/26/2005**

Organization : **Radiology Associates**

Category : **Radiologist**

Issue Areas/Comments

GENERAL

GENERAL

Dear Centers for Medicare & Medicaid Services ? Comment Division:

As a Radiologist practicing in Florida, I appreciate the opportunity to comment on the 2006 Medicare proposed fee schedule and the associated multiple-procedure discount for certain diagnostic imaging services. I am a member of a 20 physician group with four outpatient imaging centers and outpatient hospital services. We provide Medicare services that are based on the best clinical decisions for our patients and not on administrative decisions driven by costs and reimbursement.

We vigorously oppose the multiple services grouping reimbursement for this reason: Performing multiple tests requires additional time, skill, power, and resources and directly affects both patients and staff. Grouping procedures to justify a lower reimbursement provides no medical or monetary benefit to the patients and is ultimately detrimental to overall long-term patient care.

Florida has a large elderly population ? in the areas we serve, approximately 60% or greater of the population are Medicare eligible. Twenty-five percent of our practice supports the Medicare population ? imposing a 4.3% reduction in Medicare reimbursement and instituting a multiple procedure discount results in a combined revenue decrease of 6% while operating and practice expenses continue to rise. This decrease will create budget reductions in staffing, customer services, embracing new technology and other items critical to providing quality patient care and comfort.

We strongly urge you to reconsider the proposed physician payment cuts for 2006 and ask that you design a new payment system that would more appropriately reflect the cost of practicing good medicine.

Sincerely,

Charles M Burkett, MD

CMS-1502-P-1608

Submitter : Mr. Kenneth Christensen

Date: 09/26/2005

Organization : Retired

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

It is imperative for the well fare of Medicare and Medical Recipients in Sonoma County to have the medical reimbursement rates raised to more closely reflect the cost of living of our area. Failing to do so will result in less Medical Professionals willing to practice in this area, and fewer accepting medicare patients.

The demographics of this area support this increase.

Submitter : **Gregory Sheets**

Date: 09/26/2005

Organization : **Hearing Connection, LLC**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P

To Whom it May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

Gregory B. Sheets, M.S.
Clinical Audiologist

CMS-1502-P-1610

Submitter : Mrs. Jeanette Herring

Date: 09/26/2005

Organization : Mrs. Jeanette Herring

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Somona County physician fee schedule needs to be revised to include this county under the North Bay area and not as rural as it is presently designated.

Submitter : **Donna Zorich**

Organization : **Indiana Audiology**

Category : **Other Practitioner**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

It appears that the role of Audiologist is not clearly understood as is evidenced by the need to send this note under the heading of "other practioner". It is also evidenced by the plan to reduce reimbursement for our services. The audiologist not only does the testing but interprets the test results and makes appropriate recommendations to the patient or to the doctor. I hope that you will reconsider your current position on the value of our services. We not only interpret the results but take the time to explain these results to the patient and propose appropriate action to be taken as a result of these tests. Thank you for your consideration of this request. Donna Zorich, Licensed Audiologist

Submitter : Dr. Donna Selger

Date: 09/27/2005

Organization : Audio Hearing Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I would like to request that Medicare place a moratorium on the proposed rate decrease for the field of Audiology. Medicare does not put a physician work component into it's assessment of the audiologist's job. Patient management(interpertation of tests and counseling of patients) is the primary job of the audiologist. Testing needs to be interperted and most of the time this is done by the audiologist, not the ENT or the physician. Many audiologists are in private practice and they interpert and counsel for all testing. It is unfair to signal out audilogy for these reduced rates. It will certainly have negative impact on patient care if rates are further reduced and time for patient counseling is decreased. Often the audiologist is one of the only people who actually do talk to the patients about their hearing loss as well as about some of their other medical conditions.

Time is needed to collect data on the time audiologists spend with patients and what % of this time is spent in 'work'. Thank you for considering a moratorium on rate reduction. If I can be of further assistance, please let me know. info@audiohearingcenter.com

Submitter : **Mr. Kenneth Christensen**

Date: 09/27/2005

Organization : **GPCI**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

It is imperative for Seniors and other recipients of Medicare or Insurance Reimbursements that the schedule for Sonoma County be increased to more accurately reflect the cost of living and working in this county. Failure to do so will make it more difficult to attract and retain qualified health care providers plus many will refuse new medicare patients.

Please do the right thing and adjust this schedule.

Submitter : **Dr. John Michalski** **Date: 09/27/2005**

Organization : **Charlotte Eye Ear Nose and Throat Associates**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

John Michalski, Au.D.
Doctor of Audiology

Submitter : **Dr. Randall Ralston**

Organization : **Kettering Medical Center**

Date: 09/27/2005

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Beth Smith**

Date: 09/27/2005

Organization : **Allied Hearing Care**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

(Recommended letter to CMS on the proposed reduction of audiology reimbursement)
RE: CMS-1502-P
To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.
In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.
In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. CMS should consider the impact that audiologists can have on the health care system. Use of such non-physician highly specialized information could actually reduce health care costs and eliminate unnessary visits to speciality physicians, something that CMS should futher explore. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.
Sincerely,

Beth Smith, Au.D., CCC-A
Audiologist
Allied Hearing Care
110 Glancy St., Suite 214
Goodlettsville, TN 37072
(615) 868-0335
Fax (615) 868-0336

Submitter : **Dr. Kimberly Kelly**

Date: 09/27/2005

Organization : **A**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P

To Whom it May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

Dr. Kimberly J. Kelly , Au.D.

Doctor of Audiology

Submitter : Dr. Richard Orlowski

Date: 09/27/2005

Organization : NW Carolina Oncology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sirs, The proposed cuts to reimbursement for outpatient medical oncology services are draconian. We provide a full range of services to the medicare population in a professional, efficient, caring environment. This takes extensive effort and manpower on a daily basis. The proposed cuts in funding would necessitate a transfer of care of these patients elsewere as we would not be able to continue to provide these services at a financial loss. We would have to shift treatments to the hospitals and nursing staff would have to be reduced. At the hospitals the patients would not have direct access to me, would have to have transportation back and forth to the hospital, would be inconvienced at a time that they could least tolerate it, and would have to wait many hours at the hospital for their care. These are sick patients and caring for them is time consuming and labor intensive. You can not expect that this can be undertaken for free. Your calculations for administration fees are woefully inaccurate and undervalue the services that are being administered now. You will hear the loud and deathly screams of patients if your policies push them to the hospital setting. Such a change would be an enormous disaster. Please review your plan with this in mind. Take into consideration the entire process that goes on in an oncology office. Listen to the suggestions of the Community Oncology Alliance. Thank you.

Richard Orlowski, MD

Submitter : **Dr. Donald Hirt** **Date: 09/27/2005**

Organization : **Dr. Donald Hirt**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am a senior on Medicare in Sonoma County and I respectfully request that you increase reimbursement to our local physicians to be more in line with reality. I retired from practicing dentistry at Sonoma County Indian Health Project in June of this year. The city in which my wife and I live is Santa Rosa. Granted, two or three decades ago you can say this area was rural. However, now we are a city of 157,000, and Sonoma County is nearly 500,000 and growing rapidly. It is simply not fair to pay doctors in Napa and Solano counties more than you do here. Our cost of living is higher. Housing prices are higher and incomes are lower here. We have physicians no longer accepting new Medicare patients because of the low reimbursement rates. Marin county is a very expensive place to live. I know. I used to live there in the 60s and maybe its reimbursement rates should be higher than ours in Sonoma County, but we should definitely not be lower than Napa or Solano Counties. We have had a serious doctor problem here over the past ten years or so with many leaving due to high insurance costs and low insurance reimbursements, and, as you know, many or all insurance companies tie their rates to Medicare rates on a percentage basis. This causes even more financial problems for our doctors in this very high cost of living area. Please, please raise the rates. From what I have learned it seems that a 10% increase would be appropriate and fair. Thank you very much for your consideration.

Donald J Hirt

Submitter : **Dr. Shira Shiloah** **Date: 09/27/2005**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Submitter : Dr. Thomas Yuschok **Date:** 09/27/2005

Organization : Radiology Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Centers for Medicare & Medicaid Services ? Comment Division:

As a Radiologist practicing in Florida, I appreciate the opportunity to comment on the 2006 Medicare proposed fee schedule and the associated multiple-procedure discount for certain diagnostic imaging services. I am a member of a 20 physician group with four outpatient imaging centers and outpatient hospital services. We provide Medicare services that are based on the best clinical decisions for our patients and not on administrative decisions driven by costs and reimbursement.

We vigorously oppose the multiple services grouping reimbursement for this reason: Performing multiple tests requires additional time, skill, power, and resources and directly affects both patients and staff. Grouping procedures to justify a lower reimbursement provides no medical or monetary benefit to the patients and is ultimately detrimental to overall long-term patient care.

Florida has a large elderly population ? in the areas we serve, approximately 60% or greater of the population are Medicare eligible. Twenty-five percent of our practice supports the Medicare population ? imposing a 4.3% reduction in Medicare reimbursement and instituting a multiple procedure discount results in a combined revenue decrease of 6% while operating and practice expenses continue to rise. This decrease will create budget reductions in staffing, customer services, embracing new technology and other items critical to providing quality patient care and comfort.

We strongly urge you to reconsider the proposed physician payment cuts for 2006 and ask that you design a new payment system that would more appropriately reflect the cost of practicing good medicine.

Sincerely,
Thomas J. Yuschok, MD

CMS-1502-P-1622

Submitter : Dr. Mark D'Agostino

Organization : Dr. Mark D'Agostino

Category : Physician

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : Dr. David Knorz

Date: 09/27/2005

Organization : Maple-Gate Anesthesiologist

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1623-Attach-1.DOC

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

Dear Dr. McClellan:

I am writing as an anesthesiologist of the Kaleida Medical System in Buffalo, NY to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely,

David Knorz, MD

Submitter : **Dr. John Carroll**

Organization : **Dr. John Carroll**

Category : **Physician**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

Dear Centers for Medicare & Medicaid Services ? Comment Division:

As a Radiologist practicing in Florida, I appreciate the opportunity to comment on the 2006 Medicare proposed fee schedule and the associated multiple-procedure discount for certain diagnostic imaging services. I am a member of a 20 physician group with four outpatient imaging centers and outpatient hospital services. We provide Medicare services that are based on the best clinical decisions for our patients and not on administrative decisions driven by costs and reimbursement.

We vigorously oppose the multiple services grouping reimbursement for this reason: Performing multiple tests requires additional time, skill, power, and resources and directly affects both patients and staff. Grouping procedures to justify a lower reimbursement provides no medical or monetary benefit to the patients and is ultimately detrimental to overall long-term patient care.

Florida has a large elderly population ? in the areas we serve, approximately 60% or greater of the population are Medicare eligible. Twenty-five percent of our practice supports the Medicare population ? imposing a 4.3% reduction in Medicare reimbursement and instituting a multiple procedure discount results in a combined revenue decrease of 6% while operating and practice expenses continue to rise. This decrease will create budget reductions in staffing, customer services, embracing new technology and other items critical to providing quality patient care and comfort.

We strongly urge you to reconsider the proposed physician payment cuts for 2006 and ask that you design a new payment system that would more appropriately reflect the cost of practicing good medicine.

Sincerely,
John Carroll, MD

Submitter : Dr. Paul Marguglio

Date: 09/27/2005

Organization : Healdsburg Primary Care

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern:

I am a 59 year old Internist in Sonoma County, California, and former President of the Sonoma County Medical Association. In the past 10 years my partners and I have hired four young physicians to join our practice and to continue caring for the residents of Healdsburg after we retire. None have stayed because of the high cost of living and practicing in this county and the ability to earn far more in other locations. Because we cannot recruit and keep young physicians, the average age of doctors of medicine in this county is over 52 years. Patients cannot find doctors!

The modest increase in income that we would receive under this proposal would go a long way to assure an adequate supply of physicians for this county. As you are aware, we do not believe it would significantly or adversely affect other physicians or patient populations in this state.

A failure to increase reimbursement to Medicare providers in Sonoma County will result in fewer physicians accepting new Medicare patients and a deterioration of the already inadequate supply of providers. PLEASE adjust the GPCIs for our locality. Our patients need docs!

Paul J. Marguglio, M.D.

Submitter : **William Owens** **Date: 09/27/2005**

Organization : **Washington Univ. School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 26, 2005

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

RE: File Code CMS 1502-P
Dear Dr. McClellan:
I am writing as a former chair of an academic anesthesiology department at Barnes-Jewish Hospital (Washington University School of Medicine) in St. Louis, MO to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
The current Medicare payment arrangement that applies to anesthesiology teaching programs has had a serious detrimental impact on the ability of anesthesiology programs to recruit and retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
As you are aware, under current Medicare regulations, teaching surgeons, internists, cardiologists, neurologists, etc. are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted (but not reimbursed for) to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not rational, is not fair, and is not in keeping with reimbursement rules for other teaching physicians.
As a former chair of an academic department, I can assure you that this has had a very negative impact on the ability of teaching programs in anesthesiology to train future anesthesiologists, to recruit current needed faculty, and to retain good faculty for future teaching endeavors. Currently, and for the foreseeable future, there is (and will be) a severe shortage of anesthesiologists. This has major impacts on the quality and timeliness of safe anesthesia care that will be available for our aging (Medicare) population. CMS owes the Medicare population the safest anesthesia cares possible and will be neglecting it?s insured and growing population if this inequity is not corrected.
I am certainly aware of some claiming that correcting this payment methodology will have a negative impact on nurse anesthesia education. Nothing is further from the truth. The nurse anesthesia programs are also suffering because of a lack of anesthesiologists to help train them. At my institution, we also have a nurse anesthesia program that has suffered from a lack of number of faculty just as the residency program. An equitable reimbursement methodology would help us recruit and retain faculty for both programs.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching, once again, can be claimed to be the best in the word (rather than just getting by with minimal faculty).
Please end the anesthesiology teaching payment penalty.
Respectfully submitted,

William D. Owens MD
Department of Anesthesiology, Washington University School of Medicine

Submitter : James Tolkay

Date: 09/27/2005

Organization : James Tolkay

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

There are many seniors in need of medical care in Sonoma County. They are not getting help because there are not enough doctors willing to take MediCare or MediCal.

For God's sake, medical care should be our number one priority. Pay the doctors.

Submitter : Mrs. Rebecca Sallady

Date: 09/27/2005

Organization : Mrs. Rebecca Sallady

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I believe that passing the revisions to payment policies for physicians is the only way to keep physicians in Sonoma County and the state of California. I have witnessed this first hand regarding the lack of specialists in this county. I had to wait 2 weeks for an appoinment to see a specialist then I waited 2 hours in his office to see him. He is a very busy man and gave me the full attention and time I needed at my appointment. I will have to wait weeks for my surgery because of scheduling. We need more good specialists here to help with the burden of taking care of so many patiens in the community. They should get paid what they are intitled to or more of them will flee.

Submitter : **David Paulson** **Date: 09/27/2005**

Organization : **David Paulson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Santa Rosa and the surrounding areas are hardly rural and should not be classified as such. The doctors here need fair compensation, and they are not getting it. That is why they are leaving. This is a disgrace. Pay the doctors appropriately and help the ailing seniors.

CMS-1502-P-1630

Submitter : Pauline Olney

Date: 09/27/2005

Organization : Pauline Olney

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As an older person and a retired physician's wife, I hope you will revise upward the physician's fee schedule in Sonoma Cy. so that we will continue to retain and attract good doctors.

Thank you,

P.Olney

CMS-1502-P-1631

Submitter : Dr. Julia Marx

Organization : PAMF

Category : Physician

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

I support the recommended change that Santa Cruz and Sonoma counties be removed from California's locality 99. CMS has not changed this locality in almost a decade. Thank you.

Submitter : **Dr. Mordechai Bermann**
Organization : **UMDNJ**
Date: 09/27/2005
Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Mordechai Bermann, MD
Associate Professor of Anesthesia
Director of Ambulatory Anesthesia
UMDNJ-RWJMS
125 Paterson Street
New Brunswick, NJ 08901

Submitter : **Dr. William Evans**

Organization : **T.P.M.G. Inc.**

Date: 09/27/2005

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Kaiser Foundation Hospital in Sacramento to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. Medicare's current payment arrangement for anesthesiologists who supervise residents is discriminatory and needs to be the same as that used by surgeons and internists who supervise residents.
Under current regulations, surgeons and internists are allowed to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure.

However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is grossly unfair, and unreasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name__William J. Evans, D.O.______________________________
Address ____wevans@surewest.net_____________________________

Submitter : Dr. Anita Gupta

Date: 09/27/2005

Organization : Palo Alto Medical Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support the proposed change to physician payment localities that removes Santa Cruz and Sonoma Counties from California's Locality 99. CMS has not changed localities for almost a decade while the local cost of living in this area has changed dramatically.

Submitter : **Dr. Anita Gupta**

Organization : **Palo Alto Medical Clinic**

Category : **Physician**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

I support the proposed change to physician payment localities that removes Santa Cruz and Sonoma Counties from California's Locality 99. CMS has not changed localities for almost a decade while the local cost of living in this area has changed dramatically.

CMS-1502-P-1635

Submitter : Dr. PHILIP CHATHAM

Date: 09/27/2005

Organization : P.L.CHATHAM,MD.,INC.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

IT IS VERY DISTURBING THAT MEDICARE IS CUTTNG 5.6% MORE IN 2006.IN 2005, I WAS ABLE TO MANAGE BY B/O PAYMENT FOE THE DEMONSTRATION PROJECT& WAS ABLLE TO PROVIDE CARE FOR MY PATIENTS.IT WILL BE MUCH MORE DIFFICULT TO TO PROVIDE QUALITY ONCOLOGY CARE IN 2006 IF DEMO. PROJECT CUT+ 5.6% CUT + ASP CUTS ARE IMPLEMENTED.I PROBABLY WILL SEE A DROP IN INCOME OF 15 TO 20% in 2006.I am afraid THAT THIS MIGHT MAKE MY PRACTICE NON-VIABLE. I MAY BE FORCED TO SEND PATIENTS TO HOSPITAL FOR CHEMOTHERAPY WHICH IS ONLY GOING TO COST THE SYSTEM MORE & CAUSE SEVERE INCOVENIENCE FOR MY PATIENTS

PLEASE UNDERSTAND I CAN'T STAY IN BUSINESS IF MEDICARE ALLOWS JUST ABOUT OR EVEN LESS THAN WHAT I PAY FOR THE DRUGS & ON TOP OF IT PAY ONLY 80% OFIT! I AM NOT ABLE TO COLLECT THE 20% IN MANY CASES. I REQUEST YOU TO CONTINUE THE DEMO. PROJECT & ELIMINATE THE PROPOSED 5.6% CUT OF MEDICARE PAYMENTS FOR 2006.

SINCERELY,
PHILIP L. CHATHAM,MD

Submitter : **Dr. Susan Fowler**

Date: 09/27/2005

Organization : **Arizona Audiology**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

(
RE: CMS-1502-P
To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration ofp ractice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS?considerations for other non-physician practitioners.
In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.
In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.
Sincerely, Dr. Susan Fowler, Private Practice Clinical Audiologist

Submitter : **Steven Miles**

Date: 09/27/2005

Organization : **Steven Miles**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This type of regulation is very destructive to patient care.
This will further complicate care of groups of patients such as Oncology .
These patients reguire multiple studies at the same sitting to expedite care.
With the increasing cost of employees and supplies in at state with high Medicare case loads this serves to only restrict acess to high quality diagnostice imaging.
This will not decrease overutilization of MRI in healthy patients in free standing "MRI centers"
Medicare should adopt a policy to NOT pay providers who cherry pick imaging services and DO NOT provide the full spectrum of diagnositc services that hospitals and full service imaging centers do

Submitter : **Dr. Lesley Kirby** **Date: 09/27/2005**

Organization : **Lifetime Hearing Services, Inc.**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P To Whom it May Concern: I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the non-physician zero work pool codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS' considerations for other non-physician practitioners. In view of this proposed policy change that results in a four times greater reduction for audiologists' reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS' rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages. In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability and that of most audiologists to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists' reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,
Lesley Kirby, AuD

CMS-1502-P-1639

Submitter : Dr. DeElla Ray

Date: 09/27/2005

Organization : Dr. DeElla Ray

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

I am an anesthesiologist currently working in a mid-sized, non-teaching hospital in South Carolina. I am writing on behalf of my academic anesthesia colleagues to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers. As a former graduate of the anesthesia residency program at the Mayo Graduate School of Medicine (Rochester, MN), I am acutely aware of how fortunate I was to have received my training from such knowledgeable and dedicated academic faculty members. These men and women accepted the call of academic practice to further the scientific foundations of anesthetic practice and to impart to their students something not found in any textbook, the art of medicine.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure.
However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name DeElla A. Ray, M. D.
Address 304 Red Oak Lane, Aiken, SC 29803

Submitter : Dr. Wayne Soong

Date: 09/27/2005

Organization : Northwestern Memorial Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of a change in the current Medicare teaching anesthesiologist payment rule. The current payment rule seriously devalues the services provided by the teaching anesthesiologist. The future of the field of anesthesia lies in its training programs. However, these programs will face an uncertain future if teaching anesthesiologists do not achieve 100% of the Medicare fee for each of two overlapping procedures involving resident physicians. We are asking to be placed on par with our teaching surgical colleagues who receive 100% of the Medicare fee for each of two overlapping procedures. As a recent graduate of a residency training program, I cannot stress the importance of a solid educational program. I was fortunate to receive excellent training. I currently supervise resident physicians in my post-residency position. I am committed to continuing the strong tradition of vigilance, which is the basis of the American Society of Anesthesiologists. This organization has set the bar for the the medical community with regards to improving patient safety. As a larger portion of the American population lives longer, we will have a larger number of Medicare patients requiring anesthesia services. I want tomorrow's senior population to receive the same level of excellent medical care that today's senior population receives when they require anesthesia services. Please reconsider the current Medicare teaching anesthesiologist payment rule and make a committment to excellent care for the future.

Submitter : **Miss. Julie O'Shea**
Organization : **Solomon-Shotland Audiology**
Date: 09/27/2005
Category : **Other Practitioner**
Issue Areas/Comments

GENERAL

GENERAL

Hello,

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the "non-physician zero work pool" codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS' considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists'reimbursement that any other profession, CMS should impose a moratorium on reimbursement changes fro audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more that the 40 million Medicare subscribers today, particularly as CMS' rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist for over 15 years, a cut of this proportion would negatively impact my ability---and that of most audiologists-to provide the type of care patients deserve. Thus I respectfully request that CMS impose a moratorium on audiolologists' reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

Julie B. O'Shea, Au.D.
Doctor of Audiology
Solomon-Shotland Audiology & Hearing Care Associates
785 Mamaroneck Avenue
White Plains, New York 10605
914-949-0034

Submitter : Dr. Scott Sattovia **Date:** 09/27/2005

Organization : University of Iowa Hospitals and Clinics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.

Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

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

Please end the anesthesiology teaching payment penalty.

Sincerely,
Scott Sattovia, M.D.
Resident Physician
University of Iowa Hospitals and Clinics
Department of Anesthesia
200 Hawkins Drive
Iowa City, IA 52242

Submitter : Dr. Leonard Kosova

Date: 09/27/2005

Organization : Cancer Care and Hematology Specialists of Chicagol

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The drastic cuts in reimbursement for cancer treatment services will not be sustainable. If further cuts occur as is scheduled in 2006 for all physicians and more specifically for cancer physicians with disappearance of the demonstration project and further cuts in nursinf administration reimbursements, this practice will need to drastically alter its pattern of care for Medicare patiets. Many therapies will require admission to the hospital thus escalating costs to the Medicare program. Complications cared for in our offices on a daily basis will require hospital admission as well. Certain preferred therapies will no loger be available to Medicare patients since the cost of providing them will so outsrip reimbursement that the physicians will need to pay out of their own pockets to give such treatments. Hospitals are not interested in setting up outpatient facilities to give these treatments, a third best approach at best, because reimbursements to them fall far short of cost. 2006 will be a crisis year in Cancer Care unless steps are taken now to correct the errors in assumptions that were made in creating this scenario.

Submitter : **Dr. David Auyong**

Organization : **Duke University Medical Center**

Category : **Physician**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1502-P-1644-Attach-1.DOC

September 27, 2005

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

Dear Dr. McClellan:

I am writing as a resident anesthesiologist at Duke University Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy (CMS-1502-P, Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006.)

Unlike our colleagues in surgery and internal medicine, teaching anesthesiologists supervising resident physicians face a discriminatory payment penalty for each case. The Medicare payment for each case of resident supervision is reduced 50%. Surgeons are able to supervise two cases involving residents and internists are able to supervise four residents in clinic and they still receive full reimbursement from Medicare. I support a change in fee schedule to allow teaching anesthesiologists to be placed on par with other teaching physician colleagues who receive 100% of the Medicare fee for overlapping procedures performed by resident physicians.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists. As a current resident, I have seen several top academic physicians in anesthesiology leave for non-academic positions. It is imperative to retain top teaching anesthesiologists in the academic setting. Currently, the medical specialty of anesthesiology is recruiting the some of the top new physicians graduating from medical school. We must ensure their training in the field of anesthesiology is done under the supervision of expert anesthesiologists. Revising the current Medicare fee schedule will help to ensure future physicians are trained by the best anesthesiologists.

Sincerely,

David Auyong, M.D.
Box 3094
Duke University Medical Center
Durham, NC 27703
auyon001@mc.duke.edu

Submitter : Dr. Jack Shannon

Date: 09/27/2005

Organization : Texas Tech University Health Sciences Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of a change in the current Medicare teaching anesthesiologist payment rule. The current payment rule seriously devalues the services provided by the teaching anesthesiologist. The future of the field of anesthesia lies in its training programs. However, these programs will face an uncertain future if teaching anesthesiologists do not achieve 100% of the Medicare fee for each of two overlapping procedures involving resident physicians. We are asking to be placed on par with our teaching surgical colleagues who receive 100% of the Medicare fee for each of two overlapping procedures. As a recent graduate of a residency training program, I cannot stress the importance of a solid educational program. I have been fortunate to receive excellent training. I am currently in the final months of my training as an anesthesiology resident. I am committed to continuing the strong tradition of vigilance, which is the basis of the American Society of Anesthesiologists. This organization has set the bar for the the medical community with regards to improving patient safety. As a larger portion of the American population lives longer, we will have a larger number of Medicare patients requiring anesthesia services. I want tomorrow's senior population to receive the same level of excellent medical care that today's senior population receives when they require anesthesia services. Please reconsider the current Medicare teaching anesthesiologist payment rule and make a committment to excellent care for the future.

Submitter : **Mrs. Sharon Zwick-Hamilton** **Date: 09/27/2005**

Organization : **Ohio Dietetic Association**

Category : **Dietitian/Nutritionist**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1502-P-1646-Attach-1.PDF

An Affiliate of The American Dietetic Association

September 27, 2005

Dr. Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Attention: CMS-1502-P
Baltimore, MD 21244-8012.

Dear Dr. McClellan:

The Ohio Dietetic Association (ODA) is pleased to comment on the Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006. The ODA represents nearly 3,000 food and nutrition professionals who serve the public by providing Medical Nutrition Therapy and by promoting optimal health through nutrition.

ODA has two main areas of interest with the proposed rule: (1) the agency's methodology for calculating practice expense for medical nutrition therapy (MNT) codes, and (2) the proposed changes for Medicare telehealth services. These two items impact the provision of MNT services, a covered Medicare service for eligible beneficiaries with diabetes and kidney disease.

Our specific comments follow:

1. **II.A. 2.—Practice Expense Proposals for Calendar Year 2006**
   The new methodology used to determine code values (RVUs) for non-physician practitioner services does not appropriately recognize the professional RD provider work effort within the practice expense (PE) values. We urge CMS to be receptive to approaches that deal with the work of non-physicians (e.g. registered dietitians) where the statute authorizes such services, such as MNT services. In addition, we request that CMS work with the American Dietetic Association to determine an alternative methodology for establishing PE for the MNT codes. While discussions of such alternatives occur, we suggest the agency delay implementation of the 2006 PE values for the MNT codes, and instead use the 2005 values until a satisfactory methodology is determined.

34 N. HIGH STREET, NEW ALBANY, OHIO 43054-8507 USA 614/895/1253 FAX 614/895/3466
www.eatrightohio.org e-mail:oda@eatrightohio.org

2. **II.D. Telehealth.**
   ODA supports CMS' recommendation to recognize individual medical nutrition therapy (MNT) as a Medicare telehealth service. We also support CMS' proposed rule to add registered dietitians and qualified nutrition professionals to the list of practitioners who are authorized to furnish and receive payment for telehealth services. We realize that this technology is currently used by certain authorized Medicare health professionals in rural health areas with a shortage of healthcare professionals. Including MNT in the list of approved telehealth services, and extending this to RD Medicare providers will improve access and services for patient/clients in remote areas where traditional MNT services may not be readily available. According to Center for Disease Control about 20% of the U.S. population lives in rural areas. Individuals in these rural areas have a higher risk of diabetes, attributable to a population that is older, poorer and less educated. More than one half of Ohio's 88 counties are considered rural, and approximately 2,807,706 people (26%) live in these areas. The majority of this population lives in the Appalachian region, which includes a 29 county area located in southeast Ohio. Additionally the CD reports that Appalachia had the third highest overall death rate in the United States (25% of these deaths could have been prevented by the adoption of healthier lifestyles). The Appalachian population also has high rates of risk factors; people living in this region are the most inactive population in the United States and have the ninth highest obesity rate in the nation. Using the Ohio Dietetic Association's website to find a dietitian (http://www.eatrightohio.org/consumer.htm) MNT Medicare services in rural areas are extremely limited and may even be nonexistent in some areas of the state. Approving telehealth services would improve the disparity of MNT services and enhance the health of many Medicare beneficiaries living in Ohio rural areas.

Thank you for considering these comments in CMS' revisions to the 2006 Physician Fee Schedule.

Best regards,

Sharon Zwick-Hamilton, MS, RD, LD
President, Ohio Dietetic Association

Karin Palmer, RD, LD, CDE
Reimbursement & Coverage Chairman
Ohio Dietetic Association

CC: The American Dietetic Association
Policy Initiatives and Advocacy Group

Submitter : **Dr. Christine Rinder** **Date: 09/27/2005**

Organization : **Yale Dept. of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

I am writing as an academic anesthesiologist at Yale School of Medicine to urge CMS to change the Medicare anesthesiology teaching payment policy. The anesthesia-specific Medicare payment arrangement is making it impossible to recruit and keep top-flight anesthesia faculty.

Here at Yale, we are struggling to staff the operating rooms, let alone provide the teaching and conduct research as is our mandate. Residents who finish their training here, many burdened with enormous debts, are unable to stay on staff because their salary is simply too low. A place like Yale should be able to attract top graduates of American programs. Instead, we will soon be forced to choose between graduates unable to find work in the private sector and faculty that have studied and been trained outside of the U.S. Daily, thousands of patients put their lives in the hands of anesthesiologists trained in our programs. If the present trend continues, many of those anesthesiologists will have been trained by attendings that are, themselves, only adequate clinicians.

The practice of anesthesiology has made huge improvements that have significantly attenuated the mortality associated with surgery. These gains cannot be sustained if the quality of our training programs deteriorates further. Under current Medicare regulations, teaching surgeons may work with residents on overlapping cases, yet continue to receive full payment for both, so long as the teaching MD is present for key parts of each procedure. Teaching anesthesiologists, however, when similarly covering overlapping cases and present for key portions of both, are reimbursed at 50% of the usual Medicare payment. Teaching hospitals are largely in urban areas where they meet the needs of the poor and uninsured, so that Medicare is the only payment for a significant proportion of our patients. We can barely meet our operating costs at present, and further salary reductions will force many of our best people into the private sector, where they can expect 2- to 4-fold increases in their salaries.

We are not asking for special treatment. We are simply asking to be reimbursed on a par with other medical specialties. We take great pride in the quality of our trainees. Please change this payment inequity so that we may continue to attract the best and brightest to our teaching facilities.

Christine Rinder, MD
Assoc. Prof. Anesthesiology & Laboratory Medicine
Yale School of Medicine
New Haven, CT
e-mail: christine.rinder@yale.edu

CMS-1502-P-1647-Attach-1.DOC

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

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Christine Rinder, MD
Assoc. Prof. Anesthesiology & Laboratory Medicine
Yale School of Medicine
New Haven, CT
e-mail: christine.rinder@yale.edu

Submitter : Dr. Richard Wolman
Organization : University of Wisconsin-Madison Medical School
Date: 09/27/2005
Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Department of Anesthesiology
University of Wisconsin ? Madison Medical School
B6/319 Clinical Science Center
Madison, Wisconsin 53792-3272
September 27, 2005

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

Dear Dr. McClellan:
I am writing as a practicing cardiac anesthesiologist and Professor at the University of Wisconsin ? Madison Medical School to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely,

Richard L. Wolman, M.D.
Professor

CMS-1502-P-1649

Submitter : Mrs. Tracey Mooney

Date: 09/27/2005

Organization : Independent Dialysis Foundation

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1649-Attach-1.PDF

September 26, 2005

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Trinity Dialysis Center
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Phone: 410-750-8426
Fax: 410-750-8428

Deaton Center
611 S. Charles Street
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Phone: 410-752-8866
Fax: 410-752-8867

Lions Manor
Seton Drive Extended
Cumberland, MD 21502
Phone: 301-722-6272
Fax: 301-722-0754

TDD FOR DISABLED
Maryland Relay Service
1-800-735-2258

The Honorable Mark McClellan, Administrator
Attention: CMS-1502-P
Centers for Medicare & Medicaid Services
U. S. Department of Health and Human Services Room 445-G
Hubert H. Humphrey Building
200 Independence Ave, S.W.
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006

Dear Dr. McClellan:

Independent Dialysis Foundation(IDF) is a small chain of non-profit dialysis facilities located in Maryland. We had the pleasure of sharing the occasion of your honor by the AAKP this past April with our Founder, John H. Sadler, M.D. who received the Medal of Excellence that evening. IDF has been in business since 1978; our only mission is to care for those who suffer with End Stage Renal Disease. We wish to comment on the impact of the changes in reimbursement that will occur as a result of Proposed Rule: Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006.

Adequate Medicare reimbursement is critical to our dialysis facilities because it provides coverage for 90% of our patients. Our costs have been rising due to inflation, severe nursing shortages and new more costly technologies and medications. At the same time, our patient population is growing older and has more complex medical problems that we must treat. We are facing the most difficult fiscal crisis ever. We are the main provider to the University of Maryland and serve a highly indigent population. Our struggles are much greater in urban settings where the population is its poorest. Increased reimbursement is necessary for our survival. Without some relief, it appears likely all freestanding dialysis facilities will have to be sold to the large dialysis organizations, who already control 70% of dialysis care. It was exactly one year ago that we made the same plea to CMS regarding the proposed changes under the MMA that were to have such a significant blow to us. On many counts we believe you listened to the community and were responsive, it is our sincere hope that you would do the same again.

The 2005 Case Mix impact on us is hard to accurately ascertain. Every patient each new month renders us a different rate of reimbursement. The last year has been like playing ping-pong with our patient's bills. The system of payment was always bleak and now with the games played toward budget neutrality it has gone mad. We understand the pressure to reduce healthcare costs, but destructive reductions do not save, but produce new problems with new costs. As health care providers it simply makes no sense that every month the reimbursement changes for a patient because they lost or gained some weight. Our staffing requirements were still constant, prescriptions for treatment the same. Why would the payment constantly vary? The Case Mix payment mechanism is seriously flawed and has added a ridiculous amount of work to process claims. As Administrators in a world where we look for more efficient ways to deliver care, CMS should be ashamed of themselves for wasting provider time and energy on this convoluted, supposedly budget neutral payment system. The Proposed Rule calls for changes to drug reimbursement that sets reimbursement from Medicare at Average Selling Price plus 6%. The Average Selling Price as obtained by the OIG appears to be the most rock bottom pricing that could be found in their analysis. The OIG and CMS both recognize that independent facilities

have not been able to purchase ESRD drugs at ASP plus 6%; the OIG found that these facilities paid 3 to 19 percent more.

A policy that sets reimbursement at ASP plus 6 percent must be rejected because it does not represent acquisition cost for any but large chain facilities CMS has recommended that small providers, like IDF, band together in cooperative arrangements with other like providers to gain some of these economies that are enjoyed by the larger chains. As professionals in this industry that has long suffered inadequate reimbursement, we have always participated in such purchasing groups. We run a very lean, no frills shop. We have always operated in a thrifty manner and have gained access to the best pricing available. We had no choice, since we have been under funded for years. We don't have excess expenses that can be cut to make up for Medicare under reimbursing drugs. ASP +6% is being passed on to all Medicare Providers, but renal providers are much more heavily dependent on Medicare. Hospitals and Nursing Homes, for example, can make up their losses on Medicare patients with increased payer mix from commercial insurance patients. Facilities that we operate seldom see many patients with commercial coverage. Many patients who have commercial coverage lose it during the early stages of their kidney failure when they become ill and don't continue to work.

While we recognize that CMS has taken some of this into consideration by adding-on to the composite rate to offset the differences in the drug payments, this add-on is not enough and will be harmful, possibly fatal, to providers that take care of patients who have greater needs for the more costly drugs. Patients could then be forced to switch to less-effective therapies simply because they are less costly. The Proposed Rule could ultimately force rural and independent facilities to close. Our projections are devastating. The single impact of shifting from $9.76 per 1,000 units of Epogen (the most costly and heavily used drug) to $9.25 may seem nominal on a per unit basis but the impact to our 8 clinics will be lost revenue of $206,000, the drug add-on as applied does not make up the revenue and the proposal also eliminates the syringe reimbursement that at least offset some of the blow to us from the MMA changes last year.

The proposed rule includes an update to the existing wage index that is more than 20 years old and obviously outdated. As a provider who has long lobbied for a rational update it was expected this would improve the payment mechanisms. This updated rate is less than we were being paid before the MMA. As a Baltimore provider, we are the example in the Federal Register that illustrates that the reimbursement after this update goes down. Our labor cost did not go down. Since CMS is located in Baltimore and ought to have first hand knowledge of the economy locally, shouldn't it have occurred to the writers of the rule that something is very wrong here? We are mystified by the negative impact of this change; it will reduce our revenue by $250,000. We have been in touch with many of our colleagues around the country and throughout this is having a severe negative impact. We ask, if this is a budget neutral change, "Where are the winners?" We will lose in such a way that this may in fact be our last correspondence as we will be forced to succumb to this deflated reimbursement.

We urge CMS to abandon this Case Mix Methodology, reimburse Epogen at Average Acquisition Price and to go back and recalculate the wage indexes to something that reflects reality. We are running out of options to offset the inequities in the Medicare reimbursements system. We urge you not to make if worse. Additionally, we endorse the comments sent to you by the National Renal Administrators Association. We are members and appreciate the resources they have employed to very comprehensively address the problems in the revision to the fee schedule.

We welcome any further opportunity to comment. Since our clinics are close to CMS we invite you to visit to discuss first hand these matters.

Sincerely,

Tracey Mooney, CPA
Chief Financial Officer

Joan Rogers, RN
Director of Operations

Submitter : **Mrs. Marion Caldwell** **Date: 09/27/2005**

Organization : **Caldwell and Cook Hearing Services, Inc.**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.
In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.
In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.
Sincerely, Marion Caldwell, Au.D. Doctor of Audiology

Submitter : **Dr. Janice Johnson**

Organization : **Rehder Hearing Clinic**

Date: 09/27/2005

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502

To Whom It May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the 'non-physician zero work pool' codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiological care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS considerations for other non-physician practitioners.

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In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability-and that of most audiologists- to provide the type of care patients deserve. The feedback we get from local physicians regarding our interpreted test results assures us that they rely on the interpretations to aid them in the diagnosis and overall well being of the patient. Thus, I respectfully request that CMS impose a moratorium on audiologists reimbursement reductions in its most recent proposed physician fee schedule.

Respectfully,

Janice A Johnson, Au.D.

CMS-1502-P-1652

Submitter : Mrs. Joan Rogers

Date: 09/27/2005

Organization : Independent Dialysis Foundation

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1652-Attach-1.PDF

September 26, 2005

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The Honorable Mark McClellan, Administrator
Attention: CMS-1502-P
Centers for Medicare & Medicaid Services
U. S. Department of Health and Human Services Room 445-G
Hubert H. Humphrey Building
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Washington, DC 20201

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We urge CMS to abandon this Case Mix Methodology, reimburse Epogen at Average Acquisition Price and to go back and recalculate the wage indexes to something that reflects reality. We are running out of options to offset the inequities in the Medicare reimbursements system. We urge you not to make if worse. Additionally, we endorse the comments sent to you by the National Renal Administrators Association. We are members and appreciate the resources they have employed to very comprehensively address the problems in the revision to the fee schedule.

We welcome any further opportunity to comment. Since our clinics are close to CMS we invite you to visit to discuss first hand these matters.

Sincerely,

Tracey Mooney, CPA — *Chief Financial Officer*

Joan Rogers, RN — *Director of Operations*

Submitter : **Dr. Tracy Hayden** **Date: 09/27/2005**

Organization : **Rehder Hearing Clinic, Inc.**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502

To Whom It May Concern:

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Respectfully,

Tracy R. Hayden, Au.D.

Submitter : **Dr. James Benonis**

Organization : **Duke University**

Category : **Physician**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1654-Attach-1.DOC

September 27, 2005

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

Dear Dr. McClellan:

I am writing as a resident anesthesiologist at Duke University Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy (CMS-1502-P, Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006.)

Unlike our colleagues in surgery and internal medicine, teaching anesthesiologists supervising resident physicians face a discriminatory payment penalty for each case. The Medicare payment for each case of resident supervision is reduced by 50%. Surgeons are able to supervise two cases involving residents and internists are able to supervise four residents in clinic while receiving full reimbursement from Medicare. I support a change in fee schedule to allow teaching anesthesiologists to be placed on par with other teaching physicians who receive 100% of the Medicare fee for overlapping procedures performed by resident physicians.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has a serious detrimental impact on the ability of programs to retain skilled faculty to train the anesthesioloists of the future. As a current resident, I have seen several top academic physicians in anesthesiology leave for non-academic positions. It is imperative to retain top teaching anesthesiologists in the academic setting. Currently, the medical specialty of anesthesiology is recruiting some of the top new physicians graduating from medical school. We must ensure their training in the field of anesthesiology is done under the supervision of expert anesthesiologists. Revising the current Medicare fee schedule will help to ensure future physicians are trained by the best anesthesiologists.

Sincerely,

James Benonis, M.D.
Box 3094
Duke University Medical Center
Durham, NC 27703
benon001@mc.duke.edu

Submitter : James DeBoard

Organization : James DeBoard

Category : Physician

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1655-Attach-1.DOC

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

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of our program to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the shortage of anesthesia providers.

Under current Medicare regulations, teaching surgeons and internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure.

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

Medicare patients are elderly and often ill. They have less physiological reserve than younger patients. When I qualify for Medicare I will want to be treated by well-trained physician anesthesiologists. Establishing fair reimbursement for academic anesthesia will allow programs to retain good teachers and hire new ones in the future.

Please end the anesthesiology teaching payment penalty.

James W. DeBoard, MD
Anesthesiology Program Director
St. Louis University
St. Louis, Missouri

Submitter : Dr. Les Yarmush

Date: 09/27/2005

Organization : Long Island Jewish Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-1656-Attach-1.DOC

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at Long Island Jewish Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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

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

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

Please end the anesthesiology teaching payment penalty.

Name Les Yarmush_MD________________________________

Address 28 Nirvana Ave. Great Neck, NY 11023______________

CMS-1502-P-1657

Submitter : Dr. Steven Vargas

Date: 09/27/2005

Organization : R. Steven Vargas, MD Family Practice

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I am strongly in favor of passage of this measure. It is a MUST to ensure continued access to care for our seniors and also to help sustain a failing health care provider panel in Sonoma County. So many of our other private rate payors base their payments on Medicare rates, that the positive ripple effect on the health care system, particularly in our ability to attract and retain physicians in our community, will be tremendous. We've lost 24 physicians in primary care fields between Windsor and Cloverdale in the past 6 years, only 4 have been replaced and only 4 left due to retirement, the others all chosing to leave for "personal and economic reasons." This situation is dire. Please pass this measure!

Submitter : Mr. Marshall Duny

Date: 09/27/2005

Organization : Delta Oncology Associates, PC

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

I am a Medicare recipent and a survivor of cancer as well as an administrator of a oncology practice. The anticipated Medicare Payment Schedule for 2006 will force us to send patients to hospitals rather than provide chemotherapy in the office. Having a hospital background I know this will drive up the cost of delivery to Medicare recipents. This will cause the Medicare program to spend more not less money. The way to ultimately reduce costs is to keep Medicare patients in the outpatient setting rather than the hospital system.

The way to do this is to fairly pay the physician offices their costs and a reasonable profit. Not pay for bloated beurocracy, the proposed CAP program, which will drive up administrative costs which will reduce direct patient care funds to actually take care of patients such as myself. This program only contributes to the exorbident profits of the insurance companies and the drug companies of America. All one has to do is read annual reports of these companies to realize how wrong the focus has been on the delivery of medical care to the American public.

Submitter : **Dr. Peter Breen**

Organization : **Chair, Dept Anesthesiology, Univ. CA-Irvine**

Date: 09/27/2005

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached Microsoft Word file.

CMS-1502-P-1659-Attach-1.DOC

September 27, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: file code: CMS-1502-P
specific issue identifier: "TEACHING ANESTHESIOLOGISTS"

Dear Sir or Madame:

CMS's proposed changes to the Medicare fee schedule for 2006 were released on August 1, 2005. They do not include a correction of the discriminatory policy of paying teaching anesthesiologist only 50% of the fee for each of two concurrent resident cases. CMS has invited comments that would allow the current payment policy to be more flexible for teaching anesthesia programs. Accordingly, as the chairman of a major academic anesthesia department (Peter H. Breen, MD, FRCPC, Department of Anesthesiology, University of California-Irvine, UCI Medical Center, Orange, California) with a prominent residency program, I am writing you in the strongest support of changing and correcting the policy for payment of teaching anesthesiologists.

The current Medicare teaching anesthesiologist payment rule is unwise, unfair, and unsustainable. We must have a stable and growing pool of physicians trained in anesthesiology in order to provide quality medical care and patient safety for an increasingly elderly Medicare population in the United States.

Currently, resident positions in anesthesiology programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs by withholding 50% of their funds for concurrent cases. In my institution at University of California-Irvine Medical Center in Orange, California, we have 24 residents spread over the three-year residency program. Our institution cares for a significant proportion of Medicare patients. For example, in our July 2005 budget, 26% of the patients in our operating rooms were Medicare. In our Pain Medicine program, 36% of the patients were Medicare. In our area, where the ASA unit is valued at about $18-$19 for Medicare patients, we are able to collect for only a fraction of our operating costs for Medicare patients.

We have received approval from our Graduate Medical Education office at University of California-Irvine (UCI) to increase our resident numbers by two residents per year per class (total of six additional residents). We have a number of educational initiatives in the Department of Anesthesiology to improve our residency program which require an increase in resident numbers. These educational initiatives include establishment of a regional anesthesia rotation, better case assignments for residents,

better work hours and conditions for residents to maximize teaching benefit, more time and ability for residents to pursue academic and scholarly contributions, and improvement of our post operative care unit resident rotation. We need these enhancements to our residency program in order to train the best anesthesiologists for the community and for our Medicare patient population. We will not be able to fiscally achieve these educational goals without correcting the shortfall in collections for Medicare patients during anesthesia.

Anesthesiology teaching programs, such as ours at UCI Medical Center, Orange, California, are suffering severe economic losses that cannot be absorbed elsewhere. The CMS anesthesiology teaching role must be changed to allow academic departments to cover their costs. Furthermore, academic research in anesthesiology is also decreasing because departmental budgets are being severely impacted by this arbitrary Medicare reduction in payment to academic anesthesiologists.

I would like to emphasize to you that a surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case for Medicare. An internal medicine physician may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. Contrast these situations with the teaching anesthesiologist who will only collect 50% of the Medicare fee if he or she supervise residents in two overlapping cases. This is simply not fair - Medicare must pay teaching anesthesiologists on par with their surgical colleagues and similar to their internal medicine colleagues.

Please keep in mind that the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Then, reducing that by 50% for teaching anesthesiologist results in revenue that is grossly inadequate to sustain the service, teaching, and research missions of academic anesthesia training programs.

I thank you for this opportunity to comment on the teaching anesthesiologist rule. We desperately need this rule changed or academic anesthesia, and ultimately delivery of safe anesthesia to the general community, is in extreme peril.

Please feel free to contact me if you have any questions or require any further information.

Thank you.

Yours sincerely,

Peter Breen

Peter H. Breen, MD, FRCPC
Associate Professor and Chair
Department of Anesthesiology
University of California, Irvine
UCI Medical Center
Building 53, Room 227

101 City Drive South
Orange, CA 92868
Telephone: (714) 456-6652
Facsimile: (714) 456-7702
email: pbreen@uci.edu

Submitter : **Dr. Jeffrey Kelly** **Date: 09/27/2005**

Organization : **Wake Forest University Health Sciences**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment regarding CMS-1502-P as related to Medicare reimbursement for teaching anesthesiologists employed by residency training programs.

The burgeoning Medicare patient population cared for by teaching institutions, coupled with the current Medicare rule of 50% reimbursement for concurrent anesthesia resident supervision, is economically unsustainable and highly detrimental to developing the highly trained, competent anesthesiologists of the future.

Should such rules continue going forward, prudent economic planning by anesthesiology residency programs will clearly favor decreasing the number of residency positions, decreasing the quantity/quality of teaching faculty, and/or both. In my own department, it is estimated that a $430,000 shortfall occurs under current regulations relative to a full reimbursement paradigm for two concurrent anesthetics. We have also decided to decrease our number of residents from 16 to 13 per year beginning July 1, 2006. The continuous uncertainty of my department's economic health has directly contributed to many well-qualified faculty departing for private practice opportunities with more stable economics.

This 50% reimbursement rule is also grossly inconsistent with current Medicare reimbursement applicable to my surgical colleagues, who collect 100% of their Medicare fees for concurrent supervision of two overlapping cases in which they are assisted by resident trainees. Teaching anesthesiologists are only requesting to be treated similarly. I would welcome communication from Medicare administrators to explain how such discriminatory reimbursement policies could possibly be perceived as fair and reasonable.

In summary, current Medicare teaching anesthesiologist payment rules are imprudent, unfair, and create a self-fulfilling prophecy of demise for anesthesiology residency training programs. Revision to a payment paradigm consistent with teaching surgeons is long overdue and must be immediately implemented to ensure adequate numbers of qualified anesthesiologists going forward. Absent same, the sickest, most vulnerable citizens of our nation will be increasingly unlikely to receive the quality anesthesia care they deserve.

Thank you for the opportunity to comment in this matter.

Respectfully submitted,

Jeffrey S. Kelly, M.D.
Associate Professor
Anesthesiology Critical Care
Wake Forest University Health Sciences
Winston-Salem, North Carolina

Submitter : **Dr. susan steele** **Date: 09/27/2005**

Organization : **Duke University Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of a change in the current Medicare teaching anestehsiologist payment rule. The current payment rule seriously devalues the services provided by the teaching anesthesiologist. The future of the field of anesthesia lies in its training programs. However, these programs will face an uncertain future if teaching anesthesiologists do not achieve 100% of the Medicare fee for each of two overlapping procedures involving resident physicians. We are asking to be placed on par with our teaching surgical colleagues who receive 100% of the Medicare fee for each of two overlapping procedures. As a recent graduate of a residency training program, I cannot stress the importance of a solid educational program. I was fortunate to receive excellent training. I currently supervise resident physicians in my post-residency position. I am committed to continuing the strong tradition of vigilance, which is the basis of the American Society of Anesthesiologists. This organization has set the bar for the the medical community with regards to improving patient safety. As a larger portion of the American population lives longer, we will have a larger number of Medicare patients requiring anesthesia services. I want tomorrow's senior population to receive the same level of excellent medical care that today's senior population receives when they require anesthesia services. Please reconsider the current Medicare teaching anesthesiologist payment rule and make a committment to excellent care for the future.

Submitter : **Dr. Peter Breen**

Date: 09/27/2005

Organization : **Chair, Dept Anesthesiology, Univ. CA-Irvine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached file.

This may be a duplicate submission. The attached file on the first submission may have failed.

CMS-1502-P-1662-Attach-1.DOC

September 27, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: file code: CMS-1502-P
specific issue identifier: "TEACHING ANESTHESIOLOGISTS"

Dear Sir or Madame:

CMS's proposed changes to the Medicare fee schedule for 2006 were released on August 1, 2005. They do not include a correction of the discriminatory policy of paying teaching anesthesiologist only 50% of the fee for each of two concurrent resident cases. CMS has invited comments that would allow the current payment policy to be more flexible for teaching anesthesia programs. Accordingly, as the chairman of a major academic anesthesia department (Peter H. Breen, MD, FRCPC, Department of Anesthesiology, University of California-Irvine, UCI Medical Center, Orange, California) with a prominent residency program, I am writing you in the strongest support of changing and correcting the policy for payment of teaching anesthesiologists.

The current Medicare teaching anesthesiologist payment rule is unwise, unfair, and unsustainable. We must have a stable and growing pool of physicians trained in anesthesiology in order to provide quality medical care and patient safety for an increasingly elderly Medicare population in the United States.

Currently, resident positions in anesthesiology programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs by withholding 50% of their funds for concurrent cases. In my institution at University of California-Irvine Medical Center in Orange, California, we have 24 residents spread over the three-year residency program. Our institution cares for a significant proportion of Medicare patients. For example, in our July 2005 budget, 26% of the patients in our operating rooms were Medicare. In our Pain Medicine program, 36% of the patients were Medicare. In our area, where the ASA unit is valued at about $18-$19 for Medicare patients, we are able to collect for only a fraction of our operating costs for Medicare patients.

We have received approval from our Graduate Medical Education office at University of California-Irvine (UCI) to increase our resident numbers by two residents per year per class (total of six additional residents). We have a number of educational initiatives in the Department of Anesthesiology to improve our residency program which require an increase in resident numbers. These educational initiatives include establishment of a regional anesthesia rotation, better case assignments for residents,

better work hours and conditions for residents to maximize teaching benefit, more time and ability for residents to pursue academic and scholarly contributions, and improvement of our post operative care unit resident rotation. We need these enhancements to our residency program in order to train the best anesthesiologists for the community and for our Medicare patient population. We will not be able to fiscally achieve these educational goals without correcting the shortfall in collections for Medicare patients during anesthesia.

Anesthesiology teaching programs, such as ours at UCI Medical Center, Orange, California, are suffering severe economic losses that cannot be absorbed elsewhere. The CMS anesthesiology teaching role must be changed to allow academic departments to cover their costs. Furthermore, academic research in anesthesiology is also decreasing because departmental budgets are being severely impacted by this arbitrary Medicare reduction in payment to academic anesthesiologists.

I would like to emphasize to you that a surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case for Medicare. An internal medicine physician may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. Contrast these situations with the teaching anesthesiologist who will only collect 50% of the Medicare fee if he or she supervise residents in two overlapping cases. This is simply not fair - Medicare must pay teaching anesthesiologists on par with their surgical colleagues and similar to their internal medicine colleagues.

Please keep in mind that the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Then, reducing that by 50% for teaching anesthesiologist results in revenue that is grossly inadequate to sustain the service, teaching, and research missions of academic anesthesia training programs.

I thank you for this opportunity to comment on the teaching anesthesiologist rule. We desperately need this rule changed or academic anesthesia, and ultimately delivery of safe anesthesia to the general community, is in extreme peril.

Please feel free to contact me if you have any questions or require any further information.

Thank you.

Yours sincerely,

Peter Breen

Peter H. Breen, MD, FRCPC
Associate Professor and Chair
Department of Anesthesiology
University of California, Irvine
UCI Medical Center
Building 53, Room 227

101 City Drive South
Orange, CA 92868
Telephone: (714) 456-6652
Facsimile: (714) 456-7702
email: pbreen@uci.edu

Submitter : Dr. Jennifer Hartze
Organization : Micken Hearing Services
Date: 09/27/2005
Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P

To Whom it May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the "non-physician zero work pool" codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS' considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists' reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS' rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability-and that of most audioligsts-to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists' reimbursement reductions in tis most recent proposed physician fee schedule.

Sincerely,
Jennifer Hartze, Au.D.
Doctor of Audiology

Submitter : **Kay Ellison** **Date: 09/27/2005**

Organization : **Hannibal Clinic**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P
To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.
In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.
In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.
Sincerely, Kay Ellison

Submitter : **Andy Esquivel**

Date: 09/27/2005

Organization : **Andy Esquivel**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Andy Esquivel
979 Linda View
Healdsburg CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Andy Esquivel

Re: GPCIs

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

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

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

Submitter : Gerald Ogden

Organization : Gerald Ogden

Category : Individual

Issue Areas/Comments

Date: 09/27/2005

GENERAL

GENERAL

Gerald Ogden
125 Villiage Oaks
Healdsburg, CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Gerald Ogden

Re: GPCIs

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

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

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

Submitter : **Ms. Joy Schuelke** **Date: 09/27/2005**

Organization : **Ms. Joy Schuelke**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Members of the CMMS staff:
I wish to bring it to your attention that we are likely to lose several of our most experienced physicians and face a reduction in medical services in Sonoma County, California, due to the present Medicare reimbursement scheme. This is a problematic situation for a number of reasons: first of all, the population in our county has grown significantly in recent years; secondly, this region has been a magnet for a substantial number of retirees for decades already; thirdly, a rising proportion of our residents are aging "baby boomers" who will be retiring in the near future; and our costs of living in general are among the highest in the nation. Taken together with the rising costs of health care nationwide, we are being hit particularly hard by the low level of payments made to our health care professionals. Apparently, when the fee structure was established it was erroneously set as if we lived in a relatively low cost rural community, with the added dubious assumption that our demographic characteristics were more typical of those in an average county nationwide. Although our professionals have attempted to provide the best quality of care under the circumstances, they cannot continue to bear the brunt of the longstanding cost/revenue squeeze indefinitely. Therefore, without some relief from your agency, the most vulnerable of our citizens will suffer from a deteriorating system of medical services and many could be left without proper care.
I hope that you will give our uniquely serious challenge your utmost consideration.
Your time and attention to this message are most sincerely appreciated.
With Best Regards,
Joy Schuelke

Submitter : **Ernest Bassignani** **Date: 09/27/2005**

Organization : **Ernest Bassignani**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Ernest F. Bassignani
645 Spears Rd.
Santa Rosa, CA 95409

MEMORANDUM

DATE: September 27, 2005

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

FROM: Ernest Bassignani

Re: GPCIs

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

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

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

Submitter : Mrs. Dorindia Baze

Date: 09/27/2005

Organization : Columbia Basin Hematology

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. These cuts will affect patient care since it is already difficult, if not impossible, for small to medium size practices to continue to provide therapies that are currently under reimbursed. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend. Our 4 physician group is having difficulty with the current CMS payment and will definitely experience more in the future. At our office 48% of the chemotherapy drugs are paid below our cost. CMS does not reimburse for many services/supplies that we provide, in many cases does not recognizes the services at all. CMS gives substantial breaks to hospitals along with the government tax breaks for services which are not given to our type of private practices. Small practices now are being closed, or sold to hospitals as they can no longer survive Medicare and Medicaid underpayments. Mid-size practices like ours are struggling to provide services and it will be our patients that suffer long term.

Submitter : **Cecelia Bassignani**

Date: 09/27/2005

Organization : **Cecelia Bassignani**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Cecelia A. Bassignani
645 Spears Rd.
Santa Rosa, CA 95409

MEMORANDUM

DATE: September 27, 2005

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

FROM: Cecelia A. Bassignani

Re: GPCIs

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

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

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

Submitter : **Thomas Cleland** **Date: 09/27/2005**

Organization : **Thomas Cleland**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Thomas Cleland
9981 W. Dry Creek Rd.
Healdsburg CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Thomas Cleland

Re: GPCIs

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

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

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

Submitter : **Marti Phillips Abbott**

Date: 09/27/2005

Organization : **Marti Phillips Abbott**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Marti Phillips Abbott
109 Lutton Sky Rd.
Geyserville, CA95441

MEMORANDUM

DATE: September 27, 2005

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

FROM: Marti Phillips Abbott

Re: GPCIs

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

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

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

Submitter : **James Davidson** **Date: 09/27/2005**

Organization : **James Davidson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

James R. Davidson
6497 Meadow Ridge Dr.
Santa rosa, CA 95409

MEMORANDUM

DATE: September 27, 2005

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

FROM: James R. Davidson

Re: GPCIs

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

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

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

Submitter : **Mr. Ravinder Chahal** **Date: 09/27/2005**

Organization : **Medical Student**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:
I am writing as a medical student at University of Iowa, going into anesthesiology for my career to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty. Don?t push the United States healthcare into a third world medicine, based on the money and and mid-level providers. This will bite everyone in the long run, once education and training is compromised at the root levels. Lets learn lessons from other countries, where anesthesiology is run by physicians, who are well trained. AANA is trying to block this for their own monetary favor, and it is the time to curb this issue.
The AANA lobby effort against anesthesiology teaching programs is full of the same rhetoric that was thrown around Washington a few years ago during the Medicare CRNA independent practice debate. The AANA believes strongly that there is no difference in anesthesiologists and CRNAs, except that it cost a lot more to educate anesthesiologists.
The ASA leadership is furious that the AANA worked behind their back to fight the ASA led effort to help anesthesiology teaching programs, despite the AANA promise to not oppose this effort.
Name:___Ravinder Chahal
Address __2122 14th ST
Coralville, IA 52241

Submitter : **Mrs. Karen Daniels**

Date: 09/27/2005

Organization : **Radiology Associates PA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

September 26, 2005

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

Dear Centers for Medicare & Medicaid Services ? Comment Division:

As an employee of a radiology group practicing in Florida, I appreciate the opportunity to comment on the 2006 Medicare proposed fee schedule and the associated multiple-procedure discount for certain diagnostic imaging services. Our organization is a group with 20 radiologists, four outpatient imaging centers and outpatient hospital services. We provide Medicare services that are based on the best clinical decisions for our patients and not on administrative decisions driven by costs and reimbursement.

We vigorously oppose the multiple services grouping reimbursement for this reason: Performing multiple tests requires additional time, skill, power, and resources and directly affects both patients and staff. Grouping procedures to justify a lower reimbursement provides no medical or monetary benefit to the patients and is ultimately detrimental to overall long-term patient care.

Florida has a large elderly population ? in the areas we serve, approximately 60% or greater of the population are Medicare eligible. Twenty-five percent of our practice supports the Medicare population ? imposing a 4.3% reduction in Medicare reimbursement and instituting a multiple procedure discount results in a combined revenue decrease of 6% while operating and practice expenses continue to rise. This decrease will create budget reductions in staffing, customer services, embracing new technology and other items critical to providing quality patient care and comfort.

We strongly urge you to reconsider the proposed physician payment cuts for 2006 and ask that you design a new payment system that would more appropriately reflect the cost of practicing good medicine.

Sincerely,

Karen Daniels

Submitter : **Robert Pedroncelli** **Date: 09/27/2005**

Organization : **Robert Pedroncelli**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Robert Pedroncelli
77 W. Grant St.
healdsburg, CA 95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Robert B. Pedroncelli

Re: GPCIs

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

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

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

Submitter : **Herb Liberman**
Organization : **Herb Liberman**
Category : **Individual**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

Herb Liberman
990 Sunset Dr.
Healdsburg, CA 95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Herb Liberman

Re: GPCIs

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

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

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

Submitter : **Dr. Christopher Young** **Date: 09/27/2005**

Organization : **Duke University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Sincerely,

Christopher C. Young, MD
Associate Professor of Anesthesiology
Box 3094
Duke University Medical Center
Durham, NC 27710

CMS-1502-P-1678-Attach-1.DOC

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

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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

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

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

Please end the anesthesiology teaching payment penalty. It is unfair to anesthesiologists engaged in the care of patients and dedicated to the training of the next generation of physicians practicing anesthesiology.

Sincerely,

Christopher C. Young, MD

Associate Professor of Anesthesiology

Box 3094

Duke University Medical Center

Durham, NC 27710

Submitter : **Dr. Jennifer Fortney**

Date: 09/27/2005

Organization : **Duke University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of a change in the current Medicare teaching anesthesiologist payment rule. The current payment rule seriously devalues the services provided by the teaching anesthesiologist. The future of the field of anesthesia lies in its training programs. However, these programs will face an uncertain future if teaching anesthesiologists do not achieve 100% of the Medicare fee for each of two overlapping procedures involving resident physicians. We are asking to be placed on par with our teaching surgical colleagues who receive 100% of the Medicare fee for each of two overlapping procedures. I cannot over stress the importance of a solid educational program. I was fortunate to receive excellent training. I currently supervise resident physicians in at one of the top Anesthesiology training programs in the country, at Duke University Medical Center. However, the cost that each of us incurs when working with a resident physician during the care of a Medicare patient is beginning to seriously jeopardize our ability to maintain the high level of training and oversight that we have been able to provide in the past. I am committed to continuing the strong tradition of vigilance, which is the basis of the American Society of Anesthesiologists. This organization has set the bar for the medical community with regards to improving patient safety. As a larger portion of the American population lives longer, we will have a larger number of Medicare patients requiring anesthesia services. I want tomorrow's senior population to receive the same level of excellent medical care that today's senior population receives when they require anesthesia services. Please reconsider the current Medicare teaching anesthesiologist payment rule and make a commitment to excellent care for the future.

Submitter : **Dr. Mary Bolden** **Date: 09/27/2005**

Organization : **Pittsburgh Anesthesia associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Comment for change to reimbursement for Teaching Anesthesiologists:
It is grossly unfair for surgeons and internists to supervise 2 or more cases and bill at 100% while teaching anesthesiologists can only bill at 50% if we are supervising a second case.
It is difficult for us to recruit faculty at our teaching institution with an anesthesiology Residency training program (Mercy Hospital in Pittsburgh) when our reimbursemnt is low and we cannot compete salary wise with nonacademic practices.
Very few graduating residents in anesthesia are interested in teaching careers because of the low reimbursement in the face of steep medical school and residency debt.

Submitter : Ms. EDITH SAMMONS

Organization : rADIOLOGY ASSOCIATES

Date: 09/27/2005

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

September 26, 2005

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

Dear Centers for Medicare & Medicaid Services ? Comment Division:

As an employee of a radiology group practicing in Florida, I appreciate the opportunity to comment on the 2006 Medicare proposed fee schedule and the associated multiple-procedure discount for certain diagnostic imaging services. Our organization is a group with 20 radiologists, four outpatient imaging centers and outpatient hospital services. We provide Medicare services that are based on the best clinical decisions for our patients and not on administrative decisions driven by costs and reimbursement.

We vigorously oppose the multiple services grouping reimbursement for this reason: Performing multiple tests requires additional time, skill, power, and resources and directly affects both patients and staff. Grouping procedures to justify a lower reimbursement provides no medical or monetary benefit to the patients and is ultimately detrimental to overall long-term patient care.

Florida has a large elderly population ? in the areas we serve, approximately 60% or greater of the population are Medicare eligible. Twenty-five percent of our practice supports the Medicare population ? imposing a 4.3% reduction in Medicare reimbursement and instituting a multiple procedure discount results in a combined revenue decrease of 6% while operating and practice expenses continue to rise. This decrease will create budget reductions in staffing, customer services, embracing new technology and other items critical to providing quality patient care and comfort.

We strongly urge you to reconsider the proposed physician payment cuts for 2006 and ask that you design a new payment system that would more appropriately reflect the cost of practicing good medicine.

Sincerely,
EDITH SAMMONS

Submitter : **Henry McFalls**

Organization : **Henry McFalls**

Date: 09/27/2005

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Henry McFalls
227 Burgundy Rd.
Healdsburg, CA 95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Henry McFalls

Re: GPCIs

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

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

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

Submitter : **Leigh Maters**

Date: 09/27/2005

Organization : **Leigh Maters**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leigh Maters
8501 Shadetree Dr.
Windsor, CA 95492

MEMORANDUM

DATE: September 27, 2005

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

FROM: Leigh Maters

Re: GPCIs

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

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

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

Submitter : **Robert Jacobi**

Organization : **Robert Jacobi**

Date: 09/27/2005

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Robert Jacobi
3245 W. Dry Creek
Healdsburg, CA 95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Robert Jacobi

Re: GPCIs

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

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

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

Submitter :

Date: 09/27/2005

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I understand that a 17% decrease in the practice expense of the RVUs for cardiology procedures is proposed and that this proposal is based on a calculation suggesting that there is a decrease or overestimation of the cost of staffing our offices.

Although I cannot comment on the methodology upon which these conclusions are based, I can certainly share the experience of our six-person cardiology practice and other practices with which I have had conversations. Our overhead, largely determined by the number and salaries of our staff, continues to increase. The magnitude of that increase is at least 5% over the last year. This is due to the normal cost of living increases AND to the increased requirements for advanced practice and other specialized nursing support personnel to manage the increasingly complex patient problems. With the increased use of biventricular pacemakers, more stringent medical management guidelines for heart failure, hypertension and hyperlipidemia, and other advances in managing patients with cardiac disease, staffing is more expensive, NOT less expensive.

If the costs of cardiology procedures have increased out of proportion to what was anticipated, the root cause should be evaluated more specifically. Is there inappropriate use of unproven outpatient infusion therapy for heart failure? Are practitioners doing routine yearly echoes and treadmills without clinical indication? I would strongly urge CMS-contracted carriers to address the clinical indications for the excessive expenditures by benchmarking volumes and doing clinical reviews where practitioners appear to be utilizing out of proportion to their peers. Make the ?solution? truly address the problem. But, PLEASE, do not tell us that the RVUs for cardiology are being decreased because it is less expensive to staff our offices.

Submitter : Roy Domke

Date: 09/27/2005

Organization : Roy Domke

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Edward J. Heil
957 Dry Creek Rd.
Healdsburg CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Edward J. Heil

Re: GPCIs

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

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

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

Submitter : **Roy Domke**

Date: 09/27/2005

Organization : **Roy Domke**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Roy Domke
294 Bodquet Cir.
Windsor, CA 95492

MEMORANDUM

DATE: September 27, 2005

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

FROM: Roy Domke

Re: GPCIs

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

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

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

Submitter : **Mark Decker**

Organization : **Mark Decker**

Date: 09/27/2005

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Mark Decker
906 Ridge View Dr.
Healdsburg CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Mark Decker

Re: GPCIs

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

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

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

Submitter : **Dr. Michael Hill**

Organization : **Audiologist**

Category : **Other Health Care Provider**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS - 1502 - P
To Whom this may oncern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the "non-physician zero work pool" codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS' considerations for other non-physician practioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists' reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS' rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability-and that of most audiologists-to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists' reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely, Michael L. Hill AuD

Submitter : **Mr. Sherman Lord**

Date: 09/27/2005

Organization : **Pennsylvania Academy of Audiology**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Please read the attached letter RE: CMS-1502-P.

Thank you.

CMS-1502-P-1690-Attach-1.DOC

PENNSYLVANIA ACADEMY OF AUDIOLOGY

P.O. Box 1128, State College, PA 16804-1128
http://www.paaudiology.org

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E-Mail: ean1@psu.edu

September 29, 2005

RE: CMS-1502-P

To Whom it May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the non-physician zero work pool codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists' reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. A cut of this proportion would negatively impact the ability of most audiologists to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists' reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

Sherman G. Lord, M.S., FAAA
President
Pennsylvania Academy of Audiology

Submitter : Dr. BobbieJean Sweitzer
Organization : University of Chicago
Category : Physician

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

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

BobbieJean Sweitzer, M.D.

Submitter : **Dr. Stephen Small**
Organization : **University of Chicago**
Category : **Physician**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
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Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure.
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Please end the anesthesiology teaching payment penalty.

Stephen D. Small, M.D.

Submitter : **Ms. Patricia Martucci** **Date: 09/27/2005**

Organization : **Solomon-Shotland Audiology and Hearing Care Ass.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Hello, I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the "non-physician zero work pool" codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS' considerations for other non-physician practitioners. In view of this proposed policy change that results in a four times greater reduction for audiologists'reimbursement that any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more that the 40 million Medicare subscribers today, particularly as CMS' rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages. In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability---and that of most audiologists-to provide the type of care patients deserve. Thus I respectfully request that CMS impose a moratorium on audiolologists' reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

Patricia A. Martucci, M.S. CCC-A, FAAA
Audiologist
Solomon-Shotland Audiology & Hearing Care Associates
785 Mamaroneck Avenue
White Plains, New York 10605
(914)949-0034

Submitter : **Dr. Jeffrey Shaw** **Date: 09/27/2005**

Organization : **Dr. Jeffrey Shaw**

Category : **Physician**

Issue Areas/Comments

GENERAL

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9/27/05

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

Dear Dr. McClellan:
I am writing as an anesthesiologist at Abbott Northwestern Hospital in Minneapolis, MN to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

Submitter : Dr. john dilger
Organization : mayo clinic
Category : Physician

Date: 09/27/2005

Issue Areas/Comments

GENERAL

GENERAL

John A DIlger, M.D., Ph.D.
Anesthesiologist
Mayo Clinc
200 First St SW
Rochester, MN 55905

I am writing as an anesthesiologist at Mayo Clinic to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
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Please end the anesthesiology teaching payment penalty.
Sincerely,
John A Dilger MD

Submitter : **Archie Inlian**

Organization : **Archie Inlian**

Date: 09/27/2005

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Archie Inlian
1431 Prentice Dr.
Healdsburg CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Archie Inlian

Re: GPCIs

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

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

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

Submitter : **Jim Crabtree** **Date: 09/27/2005**

Organization : **Jim Crabtree**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Jim Crabtree
730 College St.
Healdsburg, CA 95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Jim Crabtree

Re: GPCIs

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

Submitter : **Eric Drew**

Organization : **Eric Drew**

Category : **Individual**

Date: 09/27/2005

Issue Areas/Comments

GENERAL

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Eric Drew
14944 McDonaugh
Healdsburg CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Eric Drew

Re: GPCIs

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

Submitter : **Richard Tang** **Date: 09/27/2005**

Organization : **Richard Tang**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Richard Tang
1691 Arbor Way
Healdsburg CA95448

MEMORANDUM

DATE: September 27, 2005

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

FROM: Richard Tang

Re: GPCIs

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Submitter : **David Anderson** **Date: 09/27/2005**

Organization : **David Anderson**

Category : **Individual**

Issue Areas/Comments

GENERAL

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David Anderson
23537 Vineyard Rd.
Geyserville, CA 95425

MEMORANDUM

DATE: September 27, 2005

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

FROM: David Anderson

Re: GPCIs

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