Submitter : Anne Olson **Date:** 09/09/2005

Organization : University of Kentucky

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-801-Attach-1.PDF

UNIVERSITY OF KENTUCKY

2 September 2005

Division of Communication Disorders
UK Wethington Building
900 S. Limestone
Lexington, KY 40536-0200
Phone: (859) 323-1100
ASHA Accredited in Speech-Language Pathology
www.uky.edu

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

Re: CMS-1502 P

Dear Dr. McClellan:

As an audiologist, I am writing to express my concern about the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

Adequate and fair reimbursement rates for audiology services are essential for covering the expenses audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. Hearing loss is a common malady of the aging population. As the lifespan of America's seniors increases, a greater need for audiology services will develop.

I respectfully request that you work with the audiology community and the American Academy of Audiology to develop solutions to address the negative impact of the elimination of the non-physician work pool. Working together, we can develop a fair and equitable reimbursement rate for audiology procedures and ensure Medicare beneficiaries' access to these vital services.

Thank you for your consideration.

Sincerely,

Anne D. Olson

Anne D. Olson, M.A. CCC/A
Assistant Professor
University of Kentucky
900 S. Limestone #124 J
Lexington, KY 40536

cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Submitter : **Deanna Frazier** **Date: 09/09/2005**

Organization : **Bluegrass Hearing Clinic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-802-Attach-1.PDF

Bluegrass Hearing Clinic

Deanna Frazier, M.A., CCC-A

September 2, 2005

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

Re: CMS-1502-P

Dear Dr. McClellan:

As an audiologist, I am writing to express my concern about the Centers for Medicare and Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. No other specialty is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

Adequate and fair reimbursement rates for audiology services are essential for covering the expenses audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. Hearing loss is a common malady of the aging population. As the lifespan of America's seniors increases, a greater need for audiology services will develop. I will remind you that hearing screenings were recently added to the enrollment physical as a covered benefit for Medicare beneficiaries in the first six months of coverage. For these Medicare patients, the benefits of having qualified and licensed audiologists who are trained to evaluate and care for them are immeasurable.

I respectfully request that you work with the audiology community and the American Academy of Audiology to develop solutions to address the negative impact of the elimination of the non-physician work pool. Working together, we can develop a fair and equitable reimbursement rate for audiology procedures and ensure Medicare beneficiaries' access to these vital services.

1036 Amberly Way, Suite A Richmond, KY 40475 (859) 623-4458

Thank you for your consideration,

Sincerely,

Deanna

Deanna L. Frazier, M.A., CCC-A
Audiologist

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

1036 Amberly Way, Suite A Richmond, KY 40475 (859) 623-4458

Submitter : **Shanna Allen** **Date: 09/09/2005**

Organization : **Fairview Rehabilitation Services**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-803-Attach-1.PDF

FAIRVIEW
Fairview Rehabilitation Services

September 2, 2005

Fairview Audiology Clinic
Phillips-Wangensteen Building
Mayo Mail Code 283
420 Delaware Street SE
Minneapolis, MN 55455
Tel 612-626-5775

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

Re: CMS-1502-P

Dear Dr. McClellan:

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Thank you for your consideration.

Sincerely,

Shanna L. Allen, M.A.
Licensed Audiologist
University of Minnesota Medical Center, Fairview

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Submitter : Dr. Don Worthington **Date:** 09/09/2005

Organization : IHC Hearing and Balance Center

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-804-Attach-1.PDF

IHC HEARING AND BALANCE CENTER
A Service of Intermountain Health Care

230 South 500 East
Suite #150
Salt Lake City, Utah 84102
(801) 595-1700
Fax (801) 559-8900

September 2, 2005

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

Re: CMS-1502-P

Dear Dr. McClellan:

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Thank you for your consideration.

Sincerely,

Don W. Worthington

Don W. Worthington, Ph.D.
Director

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Submitter : Dr. Craig Newman **Date:** 09/09/2005

Organization : The Cleveland Clinic Foundation

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-805-Attach-1.PDF

THE CLEVELAND CLINIC FOUNDATION

Head and Neck Institute

Craig W. Newman, Ph.D.
Head, Audiology
Section of Communicative Disorders / A71
Office: 216/445 8320
Appts: 216/444-6691
Fax: 216/445-9409
E mail: newmanc@ccf.org

September 2, 2005

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

Re: CMS-1502-P

Dear Dr. McClellan:

As Section Head of Audiology at The Cleveland Clinic, I am writing to express my concern about the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. No other specialty is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

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Thank you for your consideration.

Sincerely,

Craig W. Newman

Craig W. Newman, Ph.D.
Section Head, Audiology
Professor, Department of Surgery, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Submitter : Dr. Phillip Wilson **Date:** 09/09/2005

Organization : University of Texas at Dallas

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-806-Attach-1.PDF

UTD
CLINICAL DIVISION

THE UNIVERSITY OF TEXAS AT DALLAS
Callier Center for Communication Disorders
1966 INWOOD ROAD DALLAS, TEXAS 75235-7358 (214) 905 3000 (VOICE

September 2, 2005

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

Re: CMS-1502-P

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Thank you for your consideration.

Sincerely,

Phillip L. Wilson

Phillip L. Wilson, Au.D.
Head of Audiology
Callier Center for Communication Disorders
University of Texas at Dallas

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Submitter : Dr. Terry McCoy **Date:** 09/09/2005

Organization : Dr. Terry McCoy

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-807-Attach-1.PDF

September 6, 2005

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

Re: CMS-1502-P

Dear Dr. McClellan:

As an audiologist, I am writing to express my concern about the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. No other specialty is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

Adequate and fair reimbursement rates for audiology services are essential for covering the expenses audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. Hearing loss is a common malady of the aging population. Vestibular disturbances continue to be one of the most frequent complaints of the elderly. Through both vestibular diagnostics and rehabilitation, audiologists can assist in the proper diagnosis and possibly prevention of the falls that cost our healthcare system billions of dollars in hospital stays and decreased independence of the elderly. As the lifespan of America's seniors increases, a greater need for audiology services will develop. For these Medicare patients, the benefits of having qualified and licensed audiologists who are trained to evaluate and care for them are immeasurable.

I respectfully request that you work with the audiology community and the American Academy of Audiology to develop solutions to address the negative impact of the elimination of the non-physician work pool. Working together, we can develop a fair and equitable reimbursement rate for audiology procedures and ensure Medicare beneficiaries' access to these vital services.

Thank you for your consideration.

Sincerely,

Dr. Terry H McCoy, Jr., Au.D.,FAAA
Clinical Audiologist
(501) 257-1085
Arkansas Lic. Number 245

Submitter : Eric Risch **Date:** 09/09/2005

Organization : Maine Academy of Audiology

Category : Health Care Professional or Association

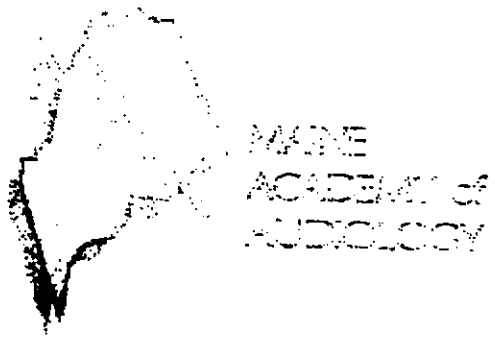
Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-808-Attach-1.PDF



September 6, 2005

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

Re: CMS-1502-P

Dear Dr. McClellan:

As an audiologist and current president of the Maine Academy of Audiology, I am writing to express my concern about the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. No other specialty is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

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Sincerely,

Eric Risch, MS

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Submitter : Dr. Steven Huart **Date:** 09/09/2005

Organization : Mayo Clinic Scottsdale

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-809-Attach-1.PDF

mayo

Mayo Clinic Scottsdale
13400 East Shea Boulevard
Scottsdale, Arizona 85259
480-301-8000

September 6, 2005

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

Re: CMS-1502-P

Dear Dr. McClellan:

As an audiologist, I am writing to express my concern about the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. No other specialty is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units. Audiometric evaluation requires sophisticated and expensive equipment. Audiologists spend a great deal of time at great expense to purchase and maintain this equipment, learn to use it, interpret the results, and treat or refer patients as appropriate. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

Adequate and fair reimbursement rates for audiology services are essential for covering the expenses audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. Hearing loss is a common malady of the aging population. As the lifespan of America's seniors increases, a greater need for audiology services will develop. For these Medicare patients, the benefits of having qualified and licensed audiologists who are trained to evaluate and care for them are immeasurable.

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Thank you for your consideration.

Sincerely,

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Submitter : Dr. Sharon Kujawa **Date:** 09/09/2005

Organization : Dr. Sharon Kujawa

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-810-Attach-1.PDF

September 6, 2005

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

Re: CMS-1502-P

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Thank you for your consideration.

Sincerely,

Sharon G. Kujawa, PhD
Audiologist

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

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

Organization : **Academy of Molecular Imaging**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1502-P-811-Attach-1.DOC

However, in the event that CMS disagrees with AMI's recommendations and does reclassify nuclear medicine services as DHS, AMI requests that the final rule exempt from the prohibition on self-referrals physician ownership arrangements that have been formed in good-faith reliance on the existing regulations.

I. Nuclear Medicine Services are not DHS Under the Physician Self-Referral Statute

The statutory text, legislative history, and CMS's own long-standing interpretation of the physician self-referral law clearly support the exclusion of nuclear medicine from the definition of DHS. Congress specifically elected not to classify nuclear medicine services as DHS. Under Section 1877(h)(6) of the Social Security Act, DHS encompass only certain enumerated services, which do not include nuclear medicine. The statute specifically lists the following services:

> *clinical laboratory services; physical therapy services; occupational therapy services;* ***radiology services, including magnetic resonance imaging, computerized axial tomography, and ultrasound services****; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.*[2]

The proposed rule acknowledges that the statute does not mention nuclear medicine. In order to bring nuclear medicine within the scope of the statutory limitations on physician self-referral, the proposed rule must therefore argue somehow that nuclear medicine is encompassed in one of the congressionally enumerated categories. CMS proposes to accomplish this by re-designating nuclear medicine procedures under what it calls "*radiology and certain other imaging services.*"[3] However, this phrase is not included in the applicable statutory provision and is clearly beyond the scope of the statutory language.

Specifically, the words *"certain other imaging services"* do not even appear in Section 1877(h)(6). In fact, Congress has expressly rejected virtually identical statutory phrasing. The original provision included the extremely broad category "*radiology, and other diagnostic services*" as DHS in Section 1877(h)(6)(D) of the Omnibus Budget Reconciliation Act of 1993.[4] The following year, however, in the Social Security Act Amendments of 1994, Congress narrowed that broad language by striking the phrase "*other diagnostic services*," and replacing it with a far more precise description of the covered services. The new, narrowly drawn category of DHS consisted of "*radiology services, including magnetic resonance imaging, computerized axial tomography, and ultrasound services.*"[5] This provision does not mention nuclear medicine or particular nuclear medicine technologies, such as PET.

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[2] 42 U.S.C. § 1395nn(h)(6) (2005).
[3] 70 Fed. Reg. 151 (Aug. 8, 2005).
[4] Public Law 103-66, Sec. 13,562 (Aug. 10, 1993).
[5] Public Law 103-432, Sec. 152 (Oct. 31, 1994).

The proposed rule now seeks to rely on language that Congress has previously rejected. If Congress had intended to broaden the scope of the statute to include nuclear medicine services it would have retained the earlier, broadly drawn category. Alternatively, Congress could have listed nuclear medicine services, such as PET, alongside of MRI, CT, and ultrasound. Instead, when Congress amended the statute, it affirmatively defined the scope of radiology services to omit nuclear medicine.

Moreover, this interpretation of Section 1877(h)(6)(D) conforms to CMS's own long-standing and well-considered view that nuclear medicine is not a radiology service for the purpose of the physician self-referral law. After carefully considering the statutory text and legislative record, CMS concluded in its January 4, 2001 final rule to "*exclude[] nuclear medicine [from DHS] because those services are not commonly considered to be radiology.*"[6] It bears emphasis that this judgment was based on a specific factual finding with respect to the proper classification of nuclear medicine.

As will be discussed below, the proposed rule offers no evidence to support reversing the factual and regulatory conclusion that it reached less than five years ago. As the Supreme Court has observed, a "settled course of behavior embodies [an] agency's informed judgment that, by pursuing that course, it will carry out the policies committed to it by Congress." Because agencies and reviewing courts alike operate under "a presumption that those policies will be carried out best if the settled rule is adhered to," an agency that departs from such a rule "is obligated to supply a reasoned analysis for the change beyond that which may be required when an agency does not act in the first instance."[7] The proposed rule does not satisfy this obligation. For CMS to reclassify nuclear medicine in the manner indicated would be to allow its preferred regulatory application to dictate its factual findings, rather than the reverse.

II. Nuclear Medicine Is a Distinct Medical Specialty from Radiology

Nuclear medicine services are clinically and technically distinct from the services that Congress enumerated when it defined the scope of "radiology services" in Section 1877(h)(6)(D). The American Board of Nuclear Medicine (ABNM), the primary certifying organization for the practice of nuclear medicine in the United States, defines nuclear medicine as "*the medical specialty that employs radionuclides to evaluate metabolic, physiologic and pathologic conditions of the body for the purposes of diagnosis, therapy and research.*"[8] In a typical procedure, a physician trained as a nuclear medicine specialist supervises the administration of a radioactive material into a patient. The subsequent distribution of this material within the body

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[6] 66 Fed. Reg. 927 (Jan. 4, 2001). More recently, CMS confirmed its practice of construing the scope of "radiology services" narrowly with respect to other (non-nuclear) procedures, finding that "angiographies, angiograms, cardiac catheterizations, and endoscopies . . . are not fundamentally radiological in nature because they do not involve an imaging service that is described in 1877(h)(6)(D) of the Act." 69 Fed. Reg. 16,104 (Mar. 26, 2004).

[7] *Motor Vehicle Manufacturers Ass'n of the U.S., Inc. v. State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29, 42-43 (1983) (quoting *Atchison, Topeka & Santa Fe Ry. v. Wichita Bd. of Trade*, 412 U.S. 800, 807 (1973) (internal citations omitted)).

[8] http://www.abnm.org/index.html (accessed June 28, 2005).

is then determined by a special device that detects the radioactivity coming from the patient. The nuclear medicine physician makes a diagnosis based on that distribution.[9]

The introduction of radiolabeled, biologically active compounds into patients distinguishes nuclear medicine from radiology. Although radiologists sometimes do administer "contrast agents," such as barium sulfate or iodine (X-ray), or gadolinium (MRI), these agents are biologically inert, and their function is entirely different from that of radioisotopes in a nuclear medicine procedure. Additionally, some of the procedures performed in nuclear medicine are for therapeutic purposes, and specialized training, such as that obtained in programs leading to certification by the ABNM, is a prerequisite for clinically appropriate use.

The proposed rule provides little in the way of independent authority to controvert its earlier position that nuclear medicine services "are not commonly considered to be radiology." The proposed rule relies, first, on an excerpt from Dorland's Illustrated Medical Dictionary and a statement by the Society for Nuclear Medicine, confirming that nuclear medicine procedures involve the introduction into the body of tracers that emit small amounts of radiation. The proposed rule appears to imply that because nuclear medicine employs radioactive material, logically it must be a subspecialty of diagnostic radiology. This implication is not warranted. Radioactive materials are used in many other areas of clinical practice--for example, the performance of radioimmunoassays and irradiation of blood products. Importantly, these procedures are not considered radiological services merely because they involve radioactive material.[10]

The proposed rule also relies on a letter from the American College of Radiology (ACR), claiming that nuclear medicine is "a part of the specialty of radiology" and noting that the American Board of Radiology's (ABR) process of certifying diagnostic radiologists includes examination in nuclear medicine. This position is directly contradicted by the American Board of Medical Specialties (ABMS), the body that officially sanctions all medical residency training programs in the United States. It is physicians trained in ABMS-approved programs, rather than the ABR, that define the specialty of nuclear medicine. According the ABMS, Nuclear Medicine and Radiology each posses "primary" (that is, fundamental and independent) board status as medical specialties. Nuclear Medicine, like Radiology, is one of only 26 distinct medical disciplines subject to Primary Board Certification. Services such as CT and MRI, by contrast, have "affiliate" status, and are among the many subspecialty groups within radiology. Moreover, the ABMS oversees separate specialty training programs in both diagnostic radiology and nuclear medicine. Although some nuclear medicine training is incorporated into the diagnostic radiology training program, and the ABR does include questions on nuclear medicine in its

---

[9] *See, e.g.*, http://www.radiochemistry.org/nuclearmedicine/definition.htm. Through PET, for example, the molecular errors that cause disease can be accurately identified and understood in terms of the specific nature of the disease. This separates PET from conventional anatomic imaging modalities such as X-ray films, CT and MRI. By assisting physicians in the diagnosis and management of tumors, cardiac disorders and neurological disorders, PET can eliminate unnecessary surgeries, reduce the number of diagnostic procedures, and otherwise help physicians to determine the best, most effective mode of treatment for a patient.

[10] In addition, hospitals and clinics frequently house nuclear medicine departments that are separate from their radiology departments, whereas ultrasound, MRI and CT are virtually always performed in radiology departments.

certification examination, physicians become eligible to take the ABNM examination only after successfully completing a nuclear medicine residency program.[11]

The proposed rule further attempts to bolster its assertion that nuclear medicine is a subcategory of radiology by citing the fact that the Social Security Act "places nuclear medicine in the same category as diagnostic radiology for coverage and payment purposes." CMS points to Section 1833(t), providing payment for "outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding mammography)," as described in Section 1833(a)(2)(E)(i). CMS interprets this provision to mean that Congress considers nuclear medicine to be a subcategory of radiology services. In fact, Section 1833(t) is strictly a payment provision, and refers to the grouping of technologies in Section 1833(a)(2)(E)(i) exclusively for the administrative purposes of providing for Medicare reimbursement.[12] Further, 1833(a)(2)(E) predates the enactment Section 1877, limiting physician self-referrals, by several years. If Congress had considered Section 1833(a)(2)(E) an authoritative description of the scope of radiology services, it could have imported that language directly into Section 1877(h)(6) when it amended the self-referral law in 1993 and 1994. The fact that Congress did not do so lends further support to the position that Congress has never considered nuclear medicine a subcategory of radiology for the purpose of Section 1877(h)(6).

Finally, the proposed rule suggests that the fact that nuclear medicine and radiological services are both paid under Section 1861(s)(3) evidences their clinical similarity. Again, the proposed rule supplies no basis for concluding that their common classification in this narrow context bears on the question of whether nuclear medicine is a subspecialty of radiology, or whether that classification represents anything more than administrative convenience. In fact, Section 1861(s)(3) applies to all diagnostic tests regardless of their clinical properties, and includes not only MRI, CT, and PET, but also diagnostic clinical laboratory tests.[13]

III. Nuclear Medicine Services are not Subject to Over-Utilization

The proposed rule offers no evidence that nuclear medicine services are abused or over-utilized. CMS maintains that any lingering doubt about whether "nuclear medicine services are radiology...within the meaning of section 1877(h)(6)" should be resolved in favor of the

[11] In addition, for a physician to be eligible for a dual certification in nuclear medicine and radiology under the ABNM program, she must first obtain separate approval for her proposed training program from both the ABNM and the ABR. After completing her training, she must then pass a certifying examination in radiology and a certifying examination in nuclear medicine, each administered by its respective certifying board.

[12] Under CMS's reading of Section 1833(t), Congress' inclusion of the catch-all category of "other imaging services" in the parenthesis following "radiology services" would make *any* imaging service a subcategory of radiology.

[13] The Section covers "diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under Section 354 of the Public Health Service Act), diagnostic laboratory tests, and other diagnostic tests."

proposed rule, because such services "pose the same risk of abuse that the Congress intended to eliminate for other types of radiology, imaging, and radiation therapy services and supplies."[14]

The empirical support cited for this claim is particularly misleading and unreliable. The proposed rule relies on a number of studies of diagnostic imaging, but none that have reviewed the utilization of any nuclear medicine service, including PET. Although the proposed rule acknowledges that the principal study on which it relies excluded nuclear imaging, it insists that there is "[no] basis for assuming that physician behavior would be different for nuclear imaging than it is for other imaging services." Imaging services encompass an extremely wide variety of technologies and clinical uses, and it is not easy to extrapolate data from one service and apply it to another. Unlike most radiology services, nuclear medicine imaging introduces radioactive material directly into the body. This is an important factor in limiting clinical use of nuclear medicine imaging to medically useful and appropriate circumstances. Second, as is discussed below, limitations on Medicare coverage for PET likewise significantly constrain its use. Unlike CT and MRI, PET is subject to numerous national coverage determinations limiting coverage to certain tumor types and indications.[15]

The proposed rule also relies on the fact that since the publication of the Phase I final rule excluding nuclear medicine services from DHS, "many more nuclear medicine procedures have been performed in physician offices or in physician-owned freestanding facilities." The proposed rule reports that while physician services in general increased by 22 percent between 1999 and 2003, imaging services increased by 45 percent, and nuclear medicine services increased by 85 percent. The implication appears to be that the absence of self-referral restrictions on nuclear medicine services has made such services increasingly, perhaps even especially, subject to over-utilization. This implication is unwarranted. Two particular considerations account for the relative growth of nuclear imaging services. First, nuclear medicine imaging still represents only a very small fraction of all diagnostic imaging. For this reason, even modest numerical growth can appear dramatic when it is presented in the form of a percentage increase. Despite PET's recent increase in utilization the total number of PET scans performed is dwarfed by the number of other imaging procedures performed, such as MRI and CT. In 2004, PET still accounted for less than one percent of Medicare reimbursement for diagnostic imaging.

Second, as the proposed rule notes, Medicare coverage of PET scans has expanded since December 2001, a change that reflects CMS's recognition of PET's utility in diagnosing and treating an increasing variety of cancers. In fact, expansion of coverage by Medicare, and not inappropriate referral, is likely the most important factor in increased utilization of PET scans. Unlike Medicare coverage of MRI and CT, coverage of PET initially was extremely limited and only applied to a handful of cancer indications and qualifying uses, such as staging. Although CMS has gradually extended PET coverage for cancer over the past four years, at present Medicare still only covers the 8 to 10 leading tumor types. Coverage also remains limited to

[14] 70 Fed. Reg. 151 (Aug. 8, 2005).
[15] *See, e.g.*, Medicare National Coverage Determinations Manual § 220.6 (Rev 35, May 6, 2005).

certain functions, such as diagnosis and staging, and does not apply to the monitoring of therapeutic response. Further, many common cancers, such as prostrate, ovarian, and testicular remain ineligible, while others, such as breast and cervical, are covered but reimbursement is confined to clinically appropriate referrals. CMS has proposed to expand coverage to all cancers, but the decision has not yet been implemented. These tight coverage policies function as an intrinsic check on the risk of exactly the kinds of over-utilization and abuse that that the self-referral prohibitions are designed to prevent. In summary, the very specific criteria enumerated in the expansion of Medicare coverage for PET scans created a scenario where the increase in utilization, sanctioned by Medicare, is highly unlikely to include clinically unnecessary or inappropriate PET scans.

As part of its proposed expansion of PET coverage, CMS is working with AMI to establish a national data registry, which will be one of the first new coverage policies instituted under Coverage with Evidence Development (CED). Any new coverage of PET would require the referring physician to submit a case report form to a data registry. The data registry will provide CMS with accurate information on how PET impacts patient management and improves health outcomes. Such information will afford CMS an invaluable tool with which to evaluate PET's utility in improving the management of oncology patients.

The proposed rule further states that the "risk of abuse and anti-competitiveness" that exists with physician self-referrals in general "is exacerbated by the greater affordability of nuclear medicine equipment."[16] This statement misapprehends both the importance of many physician-owned nuclear medicine services to patient access, and the nature of most current physician ownership interests. Because the equipment in physician-owned PET centers is expensive, typically an individual physician owns only a small percentage interest, and, as a result, has a very modest stake in the center's profitability. These small stakeholders do not have a substantial incentive to over-utilize PET scans. By including nuclear medicine as a DHS, however, the proposed rule would encourage many individual and group physician-owners to acquire expensive PET equipment to operate in their own private offices, under the in-office ancillary service exception to the self-referral rule. The proposed rule would thus result in many physicians acquiring a *more* substantial ownership interest in PET scanners than they now possess, and for that reason could exacerbate, rather than mitigate, the potential for over-utilization.

IV. Should CMS Reclassify Nuclear Medicine Services as DHS, Existing Physician Ownership Interests Should be Exempted from the Prohibition on Self-Referrals

If CMS does reclassify nuclear medicine as a DHS, contrary to the statutory language, it should take strong measures to protect current physician-stakeholders. CMS rightly acknowledges that the guidance it offered in the Phase I final rule has "*encouraged physician investment in nuclear medicine equipment and ventures, particularly PET scanners, which are very expensive and often require a substantial financial investment on the part of physician-owners.*"[17] Many

[16] 70 Fed. Reg. 151 (Aug. 8, 2005).
[17] 70 Fed. Reg. 151 (Aug. 8, 2005).

physicians have entered into ownership arrangements in good-faith reliance on the existing regulations, not least CMS's express exclusion of nuclear imaging from DHS. Accordingly, the proposed rule recognizes that it may be necessary to extend special consideration to physicians who have pre-existing ownership interests. The rule specifically requests comments on whether to delay the new rule's effective date or to "grandfather" certain arrangements. As set out below, AMI respectfully requests that CMS minimize the impact of any change to the physician self-referral requirements on both beneficiary access and physician-investors by exempting existing physician-owned nuclear medicine services from reclassification as DHS.

When Congress established, in the Medicare Modernization Act, an 18-month moratorium on physician self-referrals to specialty hospitals, it concluded that as a matter of basic fairness it would be inappropriate to apply the new prohibition to physicians who had already made substantial investments in such hospitals.[18] Accordingly, Congress provided for the grandfathering of existing facilities and those under development as of the date that the specialty hospital bill was passed by both houses. The case for grandfathering is even more compelling with respect to nuclear medicine services, because physicians have relied on CMS's express declaration that nuclear medicine is not a subspecialty of radiology. AMI urges that a similar grandfathering exemption be adopted for physician-owned nuclear medicine services, and proposes the following language:

> Any nuclear medicine service provided at a facility in operation or under development on the effective date of the final rule, and for which
>
> > (i) the number of physician investors has not increased since that date;
> >
> > (ii) the specialized services furnished by the facility have not expanded beyond imaging since that date; and
> >
> > (iii) there has not been a substantial increase in the capacity of the facility due to the addition of capital equipment, except for capital equipment acquired for the purpose of replacing or upgrading existing equipment,
>
> is not a Designated Health Service.

Conclusion

AMI believes that compelling evidence of congressional intent, the clinical distinctiveness of nuclear medicine from radiology, strong inherent checks against over-utilization, and the specific structure of physician ownership interests all counsel strongly against subjecting nuclear medicine services to the prohibition against physician self-referral. For these reasons, AMI

[18] See CMS Transmittal No. 62, March 19, 2004, available at http://www.cms.hhs.gov/manuals/pm_trans/R62OTN.pdf.

respectfully requests that CMS maintain its present policy that nuclear medicine services are not DHS. AMI would welcome the opportunity to meet with agency staff during the comment period in order to discuss these issues in more detail.

Very truly yours,

R Edward Coleman

R. Ed Coleman

Submitter : Dr. Mary Knauss **Date:** 09/09/2005

Organization : Mary Angela Knauss MD PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The proposed payment cuts to physicians will result in more and more primary care physicians opting out of Medicare and refusing to see Medicare patients. Medicare patients have more chronic diseases, and thus require more medications, tests, counseling and education. The time required to see a Medicare patient is already disproportionate to the reimbursement received. Last week I saw a new Medicare patient with multiple chronic diseases, including dementia and impaired hearing and vision. The time required for my office staff to help the patient fill out the paperwork and register the patient, and for me to interview and examine the patient and to document the visit,and then for my staff to file the claim was more than 2 hours. For this we will receive about $52.00. This is already inadequate reimbursement, and this scenario is repeated over and over again. By cutting payments to physicians even further, CMS will be forcing us to stop seeing Medicare patients and see only younger, healthier patients.

Submitter : Mr. Mahlon Foote **Date:** 09/09/2005

Organization : Mr. Mahlon Foote

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am in support of changing the designation of SANTA CRUZ COUNTY from "RURAL" to "URBAN". This change is warranted by the county's proximity to Silicon Valley and the San Francisco Bay Area and the county's high cost of living.

Submitter : Ms. Lynda Donaldson **Date:** 09/09/2005

Organization : Ortho Sports Med

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I like to understand how there can be a -4.3% in fee schedules. I cannot remember when the cost of living went down. Gas, electric, water, taxes are just a few off the top of my head that have gone up. For a small doctor offices there hasn't been one cost that has gone down for us. I just do not understand the justification of the decrease in the fee schedule. Please help me understand.

Submitter : Dr. Steven Carlson **Date:** 09/09/2005

Organization : Camino Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Under the current mechanism, providers in Santa Cruz County are significantly underfunded for their services under Medicare, which compromises access for Medicare patients. We understand that rates have not been updated for 10 years. Please update the Santa Cruz County designation.

Submitter : **Mr. Benjamin Tarver** **Date: 09/09/2005**

Organization : **Senior Citizen**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

RE: Sonoma County GAF.

I support the change being proposed to Sonoma County?s county-specific GAF. Removing Sonoma County from the Rest of California GAF and making the county its own payment locality with an 8% reimbursement rate would be a step to address the problems Sonoma County is having in retaining physicians that take Medicare patients.

I am a senior citizen. I retired to Sonoma County awhile ago, before the cost of living in this county rose dramatically. According to the Sonoma County Medical Association, 60 percent of private practice physicians no longer accept Medicare patients due to the current low reimbursement rate. This has impacted my ability to find and retain physicians. Sonoma County draws many retirees and whatever can be done to meet their medical needs must be done.

I am aware that the California Medical Association has proposed other methods of calculating GAFs but that staff is not supportive of those proposed changes. Staff?s position to change only the GAF of Santa Cruz County and Sonoma County is the first step in addressing the inequalities in reimbursement rates for Sonoma County and I support this step. Please adopt the proposed rule change as soon as possible.

Thank you.

Benjamin Tarver

Submitter : Ms. Amy Moore **Date:** 09/09/2005

Organization : International Diabetes Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Diabetes nurse educators participate in telemedicine as much as registered dietitians do, if not more. We daily take calls from patients with questions about their insulin doses, schedules, what to do if blood glucose levels are too low or too high, as well as verbally guiding a patient through techniques such as blood glucose monitoring or using an insulin pen. I believe we should be able to bill for our time on the phone providing education.

Submitter : **Ms. Mary Ann Leer** **Date: 09/09/2005**

Organization : **Ms. Mary Ann Leer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I support this change which will place physicians in Santa Cruz County on par with other counties in the San Francisco Bay Area.

Submitter : Dr. **Date:** 09/09/2005

Organization : Dr.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Re: TEACHING ANESTHESIOLOGISTS

I am writing 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 my 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.

Submitter : Dr. Herbert Brosbe **Date:** 09/09/2005

Organization : Sonoma County Medical Assn-GPCIs

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

dear Sirs, I cannot begin to tell you how difficult it is to maintain care in todays economic climate with poor reimbursement and rising costs of office support (materials, salaries, insurance for staff, etc) we cannot attract enough specialist to provide quality care for our patients. Particulary affected are our medicare patients. They require more time and care. Please do everything in your power to increase our medicare reimbursement rates. We are certainly not a rural area judged by the cost of living or the quality of care available in our medical community. Your kind support of this request is most appreciated. Yours Truly, Herb Brosbe MD

Submitter : Dr. william page **Date:** 09/09/2005

Organization : pamf

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I supportthe proposition to change to physician payment localities that reomve Santa Cruz and Sonoma counties from California, locality 99. CMS has not changed localities in nearly a decade.

Submitter : **Dr. Fredric Matlin** **Date: 09/09/2005**

Organization : **J. T. Mather Memorial Hospital**

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 J. T. Mather Memorial Hospital 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.

Fredric Jay Matlin, MD

Submitter : Mr. Adolph Smith **Date:** 09/09/2005

Organization : Mr. Adolph Smith

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Re:GPCI
To whom it may concern:
I have found the medical care in Santa Cruz county to be very satisfactory. Therefore I would like to see physicians reimbursed at a rate whic is approriate for the San Francisco Bay area. This is necessary to attract physicians to the Santa Cruz area and adequate health services.
I appreciate your attention to this matter.
Sincerely,
Adolph Smith
302 Moore Creek Road
Santa Cruz, CA 95060-2345

Submitter : **Dave Herman** **Date: 09/09/2005**

Organization : **Dave Herman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to support the change proposed in rule CMS 1502-P. Santa Cruz County is no longer a rural area. We have a University of California campus, Community College, traffic jams, increasing population density and all the characteristics of an urban area. Thousands of our residents drive into Santa Clara County to work every day. Our businesses are in the same labor market as Santa Clara businesses. Our Hospitals and Clinics are having difficulty attracting and retaining qualified physicians and other medical personnel. Please give final approval to this rule. It will give much needed relief to our beleagured health system. Thank you.

Submitter : **Mr. Lionel Watkins** **Date: 09/09/2005**

Organization : **Sutter Health**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please remove Santa Cruz County from Locality 99

Submitter : Dr. michael slesinski **Date:** 09/10/2005

Organization : palo alto med clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support change to physician payment localities removing Sant Cruz and Sonoma counties from rural local 99 status

Submitter : **Mr. Fred Bauman** **Date: 09/10/2005**

Organization : **Mr. Fred Bauman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Fred Bauman
2226 Warwick Dr.
Santa Rosa, CA 95405

Date:Sept. 9, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Fred D. Bauman

Submitter : **Dr. Tom Elwood** **Date: 09/10/2005**

Organization : **Tacoma Anesthesia Associates**

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 Tacoma General Hospital to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

I recently left academic medicine despite winning numerous teaching awards because the remuneration was so out of pace with private practice.

The burden of academic medicine with requirements for teaching, evaluation, research and administration in addition to clinical care deserves better pay, and the penalty of decreased payment for concurrent cases only worsens the prospects of retaining good teaching faculty in academic centers.

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,

Tom Elwood MD
315 Martin Luther King Jr. Way,
Tacoma, WA. 98405

Submitter : Mrs. Corinne Reichel **Date:** 09/10/2005

Organization : Mrs. Corinne Reichel

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The reimbursement for Medicare services in Sonoma County is low enough that many senior are having a difficult time finding doctors who will take them. It is important that because of the cost of doing business in our region doctors get a higher reimbursement for their services so they will be willing to add new medicare patients to their practice. The low reimbursement rate also is keeping young doctors from coming to our area and many in our physican population are reaching retirement age. Without attacting new doctors to our area we will be having a very severe shortage of medical personnel to care for the aging population in Sonoma County. The cost of living and doing business is at least as high as the San Francisco Bay Area yet physicans see a lower reimbursement to treat medicare patients. A change in the reimbursement will open new opportunties for medicare patients to see a physican closer to their home, or to see a physican at all. Higher reimbursement rates will attact new physicans to Sonoma County to keep a vital community of physican choice for seniors.
It is extremely important that Sonoma County be given a higher reimbursement rate for medicare patients immediately.

Submitter : **Karen Shores** **Date: 09/10/2005**

Organization : **Karen Shores**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Having lived in Santa Cruz County in California for 40 years I have seen it transform from a small, quiet community to a relatively large city. It seems appropriate to change the designation for Medicare and Medicaid compensation from a rural area to an urban one. Please consider this change in order to make it easier for those in this area to obtain quality medical care. I am sure you are aware that living costs are very high in this area. THank you for your consideration. Karen Shores, Santa Cruz County, California

Submitter : Alvin Tosta **Date:** 09/10/2005

Organization : Dominican Hospital Foundation Board Member

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of changing the designation of Santa Cruz County, California from "rural" to "urban". This change is warranted by our county's proximity to the Silicon Valley and San Francisco Bay area and the county's extremely high cost of living.

Submitter : **Barbara Tosta** **Date: 09/10/2005**

Organization : **Dominican Hospital Foundation Guild Member**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of changing the designation of Santa Cruz County from "rural" to "urban". This change is warranted by our county's proximity to the Silicon Valley and San Francisco Bay area and the county's extremely high cost of living.

Submitter : Nancy Martin **Date:** 09/10/2005

Organization : Nancy Martin

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of changing the designation of Santa Cruz County, California from "rural" to "urban". This change is warranted by the county's proximity to the Silicon Valley and the San Francisco Bay Area and the county's extremely high cost of living.

Submitter : Timothy Tosta **Date:** 09/10/2005

Organization : Timothy Tosta

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of changing the designation of Santa Cruz County, California from "rural" to "urban". This change is warranted by the county's proximity to the Silicon Valley and San Francisco Bay area and the county's extremely high cost of living.

Submitter : **Dr. Benjamin Fritz** **Date: 09/10/2005**

Organization : **Nephrology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Date: 9/10/05
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I 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 Medicare beneficiaries and other patients. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

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

Sincerely,

Benjamin Fritz M.D.
Nephrology Associates
1265 North Dutton Ave
Santa Rosa, CA 95404

Submitter : **Dr. Ben Fritz** **Date: 09/10/2005**

Organization : **Dr. Ben Fritz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Date:9/9/05

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

Re: GPCIs

I 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 Medicare beneficiaries and other patients. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

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

Sincerely,
Benjamin Fritz M.D.
2000 Calistoga Road
Santa Rosa, CA 95401

Submitter : **Dr. maureen nash** **Date: 09/10/2005**

Organization : **A.S.A.**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Maureen A. Nash, M.D.
10 Holder Place #4F
Forest Hills, N.Y. 11375

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

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

Please end the anesthesiology teaching payment penalty.

Sincerely,
Maureen A. Nash, M.D.

Submitter : **Dr. Jon Nordgaard** **Date: 09/10/2005**

Organization : **Sutter Santa Cruz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,
I strongly support the proposed revision to the payment localities in California that you published in the reference rule. Please see the attached letter. Thank you.
Sincerely,
Jon Nordgaard, D.P.M.

CMS-1502-P-839-Attach-1.DOC

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-1502-P
PO box 8017
Baltimore, MD 21244-8017

Re: GPCIs 9/10/05

To Whom It May Concern,

I strongly support the proposed revision to the physician payment localities in California that you published in the reference rule.

You are to be commended for addressing an important issue for physicians and Medicare beneficiaries in the San Francisco Bay Area. You have addressed the two most problematic counties in the state, and you have made an important change that will go a long way to ensuring access to care for health care services in our county.

I understand this also to be a fundamental issue of fairness. Neighboring counties to Santa Cruz and Sonoma Counties have some of the highest payment levels for physician services in the nation. The adjustment that you propose appropriately addresses the current inequitable payment problem.

CMS acknowledges that they have the responsibility to manage physician payment localities. I understand that there have no been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

I understand that CMS is interested in the opinion of the California Medical Association as it pertains to this proposed rule. I am a practicing Podiatric surgeon in Santa Cruz. The opinion of the state medical association is important for you to consider. However, they do not represent many of the health professionals who care for Medicare beneficiaries. CMS should implement this rule because it is the correct thing to do for all health care professionals and Medicare beneficiaries in California. It is becoming increasingly difficult to attract and retain high quality practitioners in our county due the Locality 99 problem. We are seeing an increasing number of practitioners being unwilling to accept Medicare patients. Please help us maintain quality healthcare for Medicare patients in Santa Cruz County.

Sincerely,

Jon Nordgaard, D.P.M.

Submitter : **Ms. Laurie Nordgaard, R.P.T.** **Date: 09/10/2005**

Organization : **Santa Cruz Medical Foundation**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,
I grow increasingly concerned with the problems that have developed as a result of the disparity in Medicare reimbursement between the contiguous Santa Cruz and Santa Clara Counties. We see a serious problem in attracting and retaining quality practitioners of all types. The California Medical Association does not represent all practitioners paid by Medicare. I would like to voice my strong support for the proposed physician payment localities revision that you published in the reference rule 1502-P. This will go a long way to re-establishing fairness to the system. It should also help to insure that practitioners will continue to accept new Medicare patients into their practices.
Very Sincerely,
Laurie Nordgaard, R.P.T.

Submitter : Mr. Jason Reed **Date:** 09/10/2005

Organization : Mr. Jason Reed

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

I feel very strongly that the reclassification of Santa Cruz County needs to change from rural to urban. I am a graduate from UC Santa Cruz, and I am familiar with the cost of living and wages earned in Santa Cruz. The wages do not support the cost of living in this area. I am currently living in San Jose, and I pay less rent than in Santa Cruz and there are more job opportunities in San Jose as well. If that is true for myself than it is also true for the health care professionals of Santa Cruz County.

Thank you for your time,
Jason Reed

Submitter : **Dr. Stephen Stayer** **Date: 09/10/2005**

Organization : **Dr. Stephen Stayer**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Stephen Stayer, M.D.
6621 Fannin, Suite A300
MC 2-1495
Houston, TX 77030

CMS-1502-P-842-Attach-1.DOC

CMS-1502-P-842-Attach-2.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 [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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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. 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.

Stephen Stayer, M.D.
6621 Fannin, Suite A300
MC 2-1495
Houston, TX 77030

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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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. 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.

Stephen Stayer, M.D.
6621 Fannin, Suite A300
MC 2-1495
Houston, TX 77030

Submitter : Dr. Scott Matthews **Date:** 09/10/2005

Organization : Palo Alto Medical Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The e-mail is to voice support for the proposed change to physician payment localities that removes Santa Cruz and Sonoma Counties from California's Locality 99. These areas are clearly merging with the greater Bay area and have commensurate high living costs.

Submitter : Mr. **Date:** 09/10/2005

Organization : Mr.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Date:9/06/05

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

Re: GPCIs

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

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

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

Sincerely, Timothy j. Tobin

Name: Timoty J. Tobin
Address:6335 Pleasant Vista Pl.
Santa Rosa,CA 95409.

Submitter : Steve James **Date:** 09/10/2005

Organization : Steve James

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the removal of Santa Cruz county from CA Locality 99 and it's assignment to its own locality.

Submitter : Ann Nitzan **Date:** 09/10/2005

Organization : Ann Nitzan

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a Medicare beneficiary and I receive care at the Santa Cruz Medical Clinic. I am asking that physicians be reimbursed at the same rate as Physicians in the San Francisco Bay area. Living expenses are the same or higher than in the San Francisco Bay area and we are unable to attract and keep physicians who treat Medicare patients to Santa Cruz area. Please inplement the proposed rule changes. Sincerely, Ann Nitzan

Submitter : Dr. Michael Springer **Date:** 09/10/2005

Organization : Dr. Michael Springer

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Physicians have seen reimbursement cuts almost every year for the last 10 or 15 years. During this time inflation and rising overhead have placed a severe economic strain on many practices. Practices which used to provide care to indigent patients may no longer be able to do so. Diagnostic technology may not be kept up to date. And, most importantly, Medicare patients will find it increasingly difficult to obtain adequate care. Many practices are already limiting new Medicare patients. In addition, we all know that these cuts are based on a formula which even federal agencies has acknowledged as being "flawed". I realize that the Federal budget is very tight and that choices must be made. I would suggest that there are thousands of areas which can and should be cut but Medicare is not one of them.

Submitter : **Ms. Kathryn Fein** **Date: 09/10/2005**

Organization : **Ms. Kathryn Fein**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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 Medicare beneficiaries and other patients. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

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

Sincerely,
Kathryn Fein
6401 Montecito Blvd #11
Santa Rosa, CA 95409

Submitter : **Mrs. Inez Bauman** **Date: 09/11/2005**

Organization : **Mrs. Inez Bauman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Date:September 10, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Name:Inez Bauman
Address: 2226 Warwick Dr.
City, State, ZIP Santa Rosa, CA, 95405

Submitter : **Date: 09/11/2005**

Organization :

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 Mount Sinai Hospital 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,
Andrey Apinis, MD
Assistant Professor,
Department of Anesthesiology
Mount Sinai Hospital
New York, NY

Submitter : **Nancy Lefler** **Date: 09/11/2005**

Organization : **Nancy Lefler**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: GPCIs

I 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 Medicare beneficiaries and other patients. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

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

Sincerely,

Nancy Lefler
474 Middle Two Rock Rd.
Petaluma, CA 94952

Submitter : **Dr. James Trapnell** **Date: 09/11/2005**

Organization : **Primary Care Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a primary care physician, and one of the dwindling few still taking new medicare patients, I can not stress enough the huge role that medicare reimbursement plays in the livelihood of my practice. Not only are the reimbursements not keeping up with the ever increasing cost of care, but for profit plans are basing their contracts using medicare as the basis. Naturally this link is causing a spiraling increase in the gap between the cost of care and the monies coming in to cover that care. Soon there will be no way to cover that discrepancy and senior will find themselves shut out of the system. If reimbursement actually declines, as is proposed by a bill in congress, this discrepancy will skyrocket, potentially bankrupting both hospitals and physicians. Hence it is imperative that where medicare reimbursements fail to cover the true costs of care, that the situation be corrected in a just and equitable manner.
Sincerely,
James Trapnell, MD
Diplomat of the American Board of Family Practice
1144 Sonoma Ave Ste. 119
Santa Rosa, CA 95405

Submitter : Mr. Stephen Payne **Date:** 09/11/2005

Organization : Defense Language Institute Foreign Language Center

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-853-Attach-1.DOC

11 September 2005

I am writing to support the proposed removal of Santa Cruz County from Medicare Locality 99, a rural designation, to an urban designation comparable to much of the greater San Francisco Bay Area. The current Medicare designation not only has the potential to harm the local retired community, those least able to afford medical care without federal assistance, but the current locality designation also harms people who believe they are covered by medical insurance.

Let me explain. Two years ago, I had emergency surgery to place a pin in my broken tibia. After three days in the hospital, I was released to recover at home. On the day I was released, my insurance company, BlueCross/BlueShield PPO Federal Employee Program, sent me a letter, acknowledging that the care I received was "approved as medically necessary... However, services provided by this non-preferred provider (the orthopaedic surgeon) will result in an increased financial responsibility for the subscriber (me)."

Soon the bills began to arrive. My insurance paid 51% of the anesthesiologist's bill only because the surgery was an emergency; normally the insurance coverage would have been much less. I paid 5%, and, as a "preferred provider", the anesthesiologist had to accept a "contract adjustment" of 44% off his bill.

When the bill from the emergency room physician, arrived, I learned that the hospital contracted out its emergency room physicians, who were not "preferred providers". My insurance "allowance" was 77% of the emergency room physician's bill, of which they paid that amount; however, I owed 23% of the original bill.

My insurance paid only 31% of the orthopaedic surgeon's bill, which is the Medicare rate for the services preformed and I was liable for 69% of the total. Had I been injured in 2001, my portion of the bill would have been a much smaller as my surgeon was a "preferred provider" then, but was forced to opt-out of BlueCross/BlueShield in 2002, due to the paltry reimbursement scale, that was negotiated by the federal government for its employees, is based on Medicare.

This year, after a follow-up surgery; I was told that I had to undergo two more surgeries, due to compilations. In order to save me some expenses, my original surgeon referred me to a "preferred provider." Fortunately, the new surgeon was another very competent surgeon and was able to correct the situation at a modest cost to me.

While I had the resources to pay for my emergency, many in Santa Cruz County do not. These people are not the "working poor" but, like me, they are middle-class citizens who pay their taxes and mortgages, provide for their loved ones, and hope that the economics of medical care does not force more health providers to opt-out of Medicare or insurance plans that are factored on the rural Medicare allotment.

As those of us who live in Santa Cruz County know, we live in one of the most expensive counties in the country to live in. If the Medicare locality is not changed to an urban designation, more and more established physicians will opt-out of Medicare and Medicare based insurance. In addition, new physicians will also opt-out of Santa Cruz and establish their practices in other areas of the United States where it is still possible for young physicians to begin a medical practice and provide a home their families.

Stephen M. Payne, PhD
1080 Fern Ridge Road
Felton, CA 95018
(831) 335-2738

Submitter : **Dr. john huebschmann** **Date: 09/11/2005**

Organization : **Dr. john huebschmann**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-854-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 Kaleida Health Systems of Buffalo to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

John Huebschmann, M.D.

--

The New York State Society of Anesthesiologists
85 Fifth Avenue, 8th Floor
New York, NY 10003
Phone: 1-212-867-7140
FAX: 1-212-867-7153
Web: http://www.nyssa-pga.org

Submitter : **Dr. Richard Beers** **Date: 09/12/2005**

Organization : **SUNY Upstate Medical University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-855-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 anesthesiologist on the faculty of SUNY Upstate Medical University, Syracuse. I write to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's payment policy, under which reimbursement is reduced by 50% when two residents are supervised concomitantly, has had and continues to have a detrimental impact on the ability of programs to retain the skilled faculty. Without adequate mentors, the widely acknowledged shortage of anesthesia providers will grow worse.

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 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, since 1995, teaching anesthesiologists are not paid in a manner consistent with other specialties; Medicare payment for each case is reduced 50%. This discriminatory policy is detrimental and unsustainable for those who work with residents.

In time, most of us will need Medicare services and may need quality and competent anesthesia care. Whether this is one or several years down the line, fair reimbursement of teaching anesthesiologists will go a long way towards ensuring that the care is there when it is needed.

Please end the anesthesiology teaching payment penalty.

Sincerely yours,

Richard A. Beers, MD
Professor, Anesthesiology
Email: beersr@upstate.edu

Submitter : **Dr. Huiling Pang** **Date: 09/12/2005**

Organization : **University of Nebraska 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 the University of Nebraska Medical Center I Omaha, Nebraska 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.

Huiling Pang, MD.PhD
Address Department of Anesthesiology, Unversity of Nebraska Medical Center, 984455 Unveristy of Nebraska Medical Center, Omaha, NE 68198

Submitter : **Date: 09/12/2005**

Organization : **Central Indiana Orthopedics**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-857-Attach-1.DOC

Central Indiana Orthopedics, PC

September 8, 2005

To Whom It May Concern:

The physicians of Central Indiana Orthopedics would like to express their concern for the proposed 2006 Medicare fee schedule. As a practice in East Central Indiana with 20 physicians and 7 physician extenders we treat over 7500 Medicare patients each year. As a population, Medicare patients, take much more time and medical expertise to care for. Recovery times are often longer requiring more physician involvement. It is the first priority of our practice to provide excellent healthcare to all of our patients. However, with the continued cuts in government reimbursement and an aging population this task becomes more difficult each year. Our practice has projected a loss of over $240,000 should the proposed fees take place. This would represent a significant challenge to providing the high quality healthcare we pride ourselves in.

As part of our practice we offer a same day access clinic to members of the East Central Indiana community. Through this clinic we treat numerous fractures for the Medicare population. The proposed elimination of separate reimbursement of casting supplies would have cost our practice approximately $6000.00 last year. In an environment of continually increasing overhead and decreasing reimbursement this is simply not acceptable.

Central Indiana Orthopedics, in an effort to provide centralization and simplicity, for those requiring diagnostic testing also offers Magnetic Resonance Testing on site. The proposed multiple imaging discounts may force us to re-evaluate our ability to offer this service to the Medicare population.

We appreciate the opportunity to formally register our dissatisfaction with the proposed 4.4 % reduction (see table) in physician reimbursement. Please feel free to contact us should any additional information be required.

Impact of Proposed Rule Provisions on Orthopaedic Surgery					
Medicare allowed charges for 2004 ($ in millions)	Impact of PE RVU changes (percent)	Impact of malpractice RVU changes (percent)	Impact of multiple imaging discount (percent)	Impact of all proposed changes (percent)	Combined impact (including update and drug admin. trans.) (percent)
$3,145	-0.4	0.1	.2	-0.1	-4.4
					AAOS 08/2005

Sincerely,

Vivek Agrawal, M.D.
Kerry Bennett, D.O.
David Graybill, M.D.
Kenneth Haller, D.O.
Stephen Hampton, M.D.
Jeffrey Heavilon, M.D.
Gregory Hellwarth, M.D.
Steven Herbst, M.D.
Jeremy Hunt, M.D.
Joseph Jerman, M.D.
Jared Jones, M.D.
Patrick Kay, M.D.
Robert Lillo, M.D.
L. Jay Matchett, M.D.
Keith Miller, M.D.
Michael Sathy, M.D.
Stephen Shick, M.D.
Nirmal Surtani, M.D.
Francesca Tekula, M.D.
Karey Claywell, PAC
Laurel Fauquher, PAC
Brenda Heinen, NP
Todd Nisley, PAC
Matthew Stinson, PAC
Sheri Stohler, NP
J. Greg Williamson, PAC

Submitter : Dr. Matthew Hansman **Date:** 09/12/2005

Organization : Dr. Matthew Hansman

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County has had the worst physician/provider cost/payment mismatch in the state for nine years. (Currently at 11%) It has the worst boundary payment discrepancy in the nation. (A 25% difference between Santa Cruz and Santa Clara Counties) This is leading to growing physician exodus and increasing access problems for our seniors.

Submitter : Mrs. Ellen Marsk **Date:** 09/12/2005

Organization : Sonoma National Bank

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

It is important that physician reimbursement rates for Medicare are increased for Sonoma County, California. We are losing physicians (especially specialists) in our area because of the high cost of living. Physicians are being caught between high cost of doing business and low reimbursement. Before our doctor shortage hits crisis proportions, please do something about this.

Submitter : **Mrs. Michelle Nix** **Date: 09/12/2005**

Organization : **Palo Alto Medical Foundation**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

This fee schedule change will truly help the patients who are loosing their providers to other areas of the state where reimbursement is more aligned with the cost of living and health care services provided. Please approve.

Submitter : Mr. Raymond Fletcher **Date:** 09/12/2005

Organization : none

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The cost of living here in Sonoma County, CA are just as high as in Marin and Napa counties, but our physicians get much less compensation than doctors who only live a few miles away. We are losing doctors to other counties, some are retiring early and we are having a difficult time in attracting new physicians. It is important to our health care that medicare reinbursement rates be increased for Sonoma County, CA. Thank you.
My wife also agrees with this.
Ray and Denise Fletcher, Petaluma, CA 94954

Submitter : Mr. James Fahy

Date: 09/12/2005

Organization : Mr. James Fahy

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please correct the severe disadvantage suffered by the medical profession of Sonoma County.

Submitter : Dr. Douglas Martz, Jr. **Date:** 09/12/2005

Organization : Univ of MD Dept of Anesthesiology

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

The current Medicare teaching anesthesiologist payment rule is unfair, unwise and unsustainable. A surgeon may supervise residents in two overlapping operations and collect 100% of the Medicare fees allowed for each case. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the Medicare fees allowed for each patient. However, a teaching anesthesiologist will only collect 50% of the Medicare allowed if he/she supervises residents on two overlapping cases. This is not fair and is not reasonable. Teaching anesthesiologists should be paid on par with their surgical colleagues.

We currently have 32 residents, 3 pain fellows on staff. Four faculty openings exist at the University of Maryland Anesthesiology program. It is difficult for us to retain and recruit faculty due to budget shortfalls and non-competitive salaries which can be directly attributed to the Medicare teaching anesthesiology reimbursement methodology. Our hospital partners subsidize the anesthesiology program with payments of $6.5 million annually and they cannot sustain this level of support into the future.

Roughly 25% of our current patients are Medicare patients and the increasing elderly population will reduce our ability to be viable unless the arbitrary Medicare reduction is remedied. These reductions do not allow us to cover our costs (currently we lose roughly $500,000 annually due to this reimbursement methodology) and may lead to reduction in our training programs and our ability to care for Medicare patients.

Submitter : **Ms. Lee Abamson** **Date: 09/12/2005**

Organization : **Ms. Lee Abamson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs-See Attachment

CMS-1502-P-864-Attach-1.DOC

CMS-1502-P-864-Attach-2.DOC

Lee Abramson
2560 Barona Place
Santa Rosa, CA 95404

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Lee Abramson
2560 Barona Place
Santa Rosa, CA 95404

cc: Two copies attached.

Lee Abramson
2560 Barona Place
Santa Rosa, CA 95404

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Lee Abramson
2560 Barona Place
Santa Rosa, CA 95404

cc: Two copies attached.

Submitter : **Barbara Fromm** **Date: 09/12/2005**

Organization : **Barbara Fromm**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I would like to support the proposed change of Medicare payment locality for Sonoma County. It has become incredibly costly to live here, as or more costly than nearby counties which are in payment localities with higher reimbursement rates for physicians. I recently moved to Sonoma County & understand that increasing numbers of doctors are refusing to accept new Medicare patients. In the interests of equality, the proposed change should be enacted.

Sincerely,
Barbara Fromm

Submitter : Teresa Abamson **Date:** 09/12/2005

Organization : Teresa Abamson

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-866-Attach-1.DOC

Teresa N. Abramson
2560 Barona Place
Santa Rosa, CA 95404

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Teresa N. Abramson
2560 Barona Place
Santa Rosa, CA 95404

cc: Two copies attached.

Submitter : **John Allan** **Date: 09/12/2005**

Organization : **John Allan**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-867-Attach-1.DOC

John Allan
6566 Lincoln St.
Petaluma, CA 95492

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

John Allan
6566 Lincoln St.
Petaluma, CA 95492

cc: Two copies attached.

Submitter : **Dr. Lisa Farmer** **Date: 09/12/2005**

Organization : **UTMB- Department of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at University of Texas Medical Branch 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 Lisa R. Farmer M.D.
Address 10206 Cloud Lane Galveston, TX 77554

Submitter : **Mrs. KAREN LLOYD** **Date: 09/12/2005**

Organization : **Mrs. KAREN LLOYD**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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 Medicare beneficiaries and other patients. 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. PETER LLOYD **Date:** 09/12/2005

Organization : Mr. PETER LLOYD

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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 Medicare beneficiaries and other patients. 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 : Susan G Snow **Date:** 09/12/2005

Organization : Susan G Snow

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-871-Attach-1.DOC

Susan G. Snow
601 Hetts Lane
Sebastopol, CA 95472
susansnow@sbcglobal.net

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

RE: GPCIs

Sirs:

I am a Medicare beneficiary who receives medical care from two or three physicians in Sonoma County, California.

I am in support of the proposal to change Sonoma County's payment locality.

I do believe that the current rate does not cover the actual practice expenses. Sonoma County is an expensive county in many categories of living, quite similar to Napa and Marin Counties, two contiguous counties. A new payment locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. It would also encourage new physicians to move into the area and would help us retain those physicians that are already here.

Thank you.

Sincerely,

Susan G. Snow

Submitter : **Mr. ROBERT LLOYD** **Date: 09/12/2005**

Organization : **Mr. ROBERT LLOYD**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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 Medicare beneficiaries and other patients. 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 : **Manuel Bonilla** **Date: 09/12/2005**

Organization : **Manuel Bonilla**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

ANESTHESIOLOGY TEACHING

I am writing to urge CMS to eliminate the 50% anesthesiology teaching payment penalty.

The payment reductions which result from the penalty threaten the strength of the nation's anesthesiology teaching programs.

Submitter : **Dr. Robert Schlamowitz** **Date: 09/12/2005**

Organization : **Robert A. Schlamowitz, M.D., F.A.C.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in protest of the proposed reduction in reimbursement for CPT code 93701, Thoracic Electrical Bioimpedance. The costs of electrodes has risen over the past two years as has the cost of staff time, malpractice and all business office related costs. This test allows appropriate management of my Medicare patients' hypertension and cardiac diseases. I cannot continue to provide service to my Medicare patients when the continually reduced reimbursement for doing so makes my continued practice financially untenable. There is not a single aspect of providing care to my Medicare patients that has become less costly over the years and Medicare's reduced practice expense calculations are unrealistic and untenable.

Submitter : Dr. Casey Schirmer **Date:** 09/12/2005

Organization : Santa Cruz Medical Foundation

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County has had the worst physician cost/payment mismatch in the state for the last nine years. Our area has one of the highest costs of living, and the reimbursement rates for Medicare are outdated. The changes purposed for Locality 99 are reasonable and fair. I support this effort to adjust the fee schedule changes. Thank you

Submitter : **Dr. Rebecca Dalmeida** **Date: 09/12/2005**

Organization : **self**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment, my personal letter regarding the teaching rule and academic anesthesiology practice experience. Note: I left academics and now do private practice in Phoenix, AZ

CMS-1502-P-876-Attach-1.DOC

Rebecca E. Dalmeida, M.D.

5958 W. Topeka Dr.
Glendale, AZ 85308
623-376-9014

September 12, 2005

Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
attn. CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

To Whom It May Concern:

My name is Rebecca E. Dalmeida, M.D. and I am anesthesiologist currently in private practice in the Phoenix, Arizona metro area. I am writing you regarding the current Anesthesiology Teaching Rule reimbursement scheme. In May the ASA was assured that the unfair reimbursement scheme applied to teaching anesthesiologists, but not surgeons would be amended. Several months later we were informed that the CMS does not intend to address this issue this year. I find this response totally unacceptible.

I taught anesthesia for 10 years at Baylor College of Medicine in Houston, the University of Texas Medical Branch in Galveston, and at the University of Kentucky in Lexington. Five years ago I left teaching due to the economic problems that academics is experiencing due to reimbursements schemes such as the one your agency applies to anesthesia. I would like to share my experience with you in an attempt to educate you as to why anesthesiologists, even more than surgeons, should be paid appropriately for the supervised cases they do.

During my teaching time I usually covered two rooms resident rooms at once. For each case the resident and I went over the patient history, and the anesthetic plan in great detail prior to induction of anesthesia. I spent a lot of time going over the history and the plan not only to provide a thorough education experience for the resident, but also to ensure that the resident had not missed any valuable information that would impact on my patient's care. I was present for each case's induction of anesthesia, line placement and emergence, plus was in and out of both rooms frequently to closely monitor the patient's condition and to further teach the residents during the cases. If cases required one-on-one supervision due to the acuity of the patient care needed, I arranged for another faculty member to cover my other room so that I could devote my entire attention to the

patient that needed it. If I thought a resident would not follow my instructions and could harm a patient, I had that resident removed and did the case myself. Patients discharged from the recovery room were seen by me personally prior to release.

In all cases, the residents were aware that I considered myself totally responsible for the wellbeing of my patients. Overall, I spent more time in any case I supervised than any of the attending surgeons at any of the facilities I attended. I find it odd that the surgeons brief periods of attendance are considered adequate for full reimbursement, and the marked increased presence of the anesthesiology faculty as less. At each of the institutions I attended, the anesthesiology faculty were the only faculty routinely in-house, while the surgical faculty consulted from home, or popped in for only a portion of the case. Additionally, the anesthesiology faculty was often the only faculty present at any of the codes. I rarely saw a surgical faculty person attend a code even on their own patients.

In summary, I hope my letter will serve to educate you as to the amount of involvement the anesthesiologist faculty have with the patients under their care. I strong urge that you rectify the reimbursement situation before more faculty decide as I did to go into private practice so that I could have a more reasonable income. Currently many institutions are having problems recruiting and retaining good faculty. I know from my own peers many good teachers who loved teaching who are now in private practice not because they wanted to stop teaching, but because they got tired of the continued financial problems they were facing in the academic world. Good anesthesiologists are needed by this country, and good teaching programs are the only way to get them. Financially supporting these institutions is the only way to ensure a future with good anesthesiologist in it.

Sincerely,

Rebecca E. Dalmeida, M.D.

Submitter : GRACE ALLEY **Date:** 09/12/2005

Organization : GRACE ALLEY

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-877-Attach-1.DOC

Grace Alley
387 Magnolia Dr.
Petaluma, CA 94952

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Grace Alley
387 Magnolia Dr.
Petaluma, CA 94952

cc: Two copies attached.

Submitter : LIONA ANDREW **Date:** 09/12/2005

Organization : LIONA ANDREW

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-878-Attach-1.DOC

Liona Andrew
PO Box 845
Clearlake, CA 95424

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Liona Andrew
PO Box 845
Clearlake, CA 95424

cc: Two copies attached.

Submitter : MARILYN ANDREWS **Date:** 09/12/2005

Organization : MARILYN ANDREWS

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-879-Attach-1.DOC

Marilyn Andrews
1220 Barlow Lane
Sebastopol, CA 95472

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Marilyn Andrews
1220 Barlow Lane
Sebastopol, CA 95472

cc: Two copies attached.

Submitter : YOLANDA BALDUFF **Date:** 09/12/2005

Organization : YOLANDA BALDUFF

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-880-Attach-1.DOC

CMS-1502-P-880-Attach-2.DOC

Yolanda Balduff
423 Alta Ave.
Rohnert Park, CA 94928

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Yolanda Balduff
423 Alta Ave.
Rohnert Park, CA 94928

cc: Two copies attached.

Yolanda Balduff
423 Alta Ave.
Rohnert Park, CA 94928

September 7, 2005

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

Re: GPCIs

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

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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.

Sincerely,

Yolanda Balduff
423 Alta Ave.
Rohnert Park, CA 94928

cc: Two copies attached.

Submitter : ROLLIN BARTON **Date:** 09/12/2005

Organization : ROLLIN BARTON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-881-Attach-1.DOC

Rollin Barton
1888 Judson Ln.
Santa Rosa, CA 95401

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Rollin Barton
1888 Judson Ln.
Santa Rosa, CA 95401

cc: Two copies attached.

Submitter : JUDY BEACH **Date:** 09/12/2005

Organization : JUDY BEACH

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-882-Attach-1.DOC

Judy Beach
850 Russell Ave. #E9
Santa Rosa, CA 95403

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Judy Beach
850 Russell Ave. #E9
Santa Rosa, CA 95403

cc: Two copies attached.

Submitter : JACQUELINE BEAN **Date:** 09/12/2005

Organization : JACQUELINE BEAN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-883-Attach-1.DOC

Jacqueline Bean
127 Railroad Ave. #5
Cloverdale, CA 95425

September 7, 2005

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

Re: GPCIs

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

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

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

Sincerely,

Jacqueline Bean
127 Railroad Ave. #5
Cloverdale, CA 95425

cc: Two copies attached.

Submitter : GEREIVE BEAVERT **Date:** 09/12/2005

Organization : GEREIVE BEAVERT

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-884-Attach-1.DOC

Gereive Beavert
58 Brianee
Windsor, CA 95492

September 7, 2005

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

Re: GPCIs

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

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Sincerely,

Gereive Beavert
58 Brianee
Windsor, CA 95492

cc: Two copies attached.

Submitter : FRANCES BEGUN **Date:** 09/12/2005

Organization : FRANCES BEGUN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-885-Attach-1.DOC

Frances Begun
1030 Martin Lane
Sebastopol, CA 95472

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Frances Begun
1030 Martin Lane
Sebastopol, CA 95472

cc: Two copies attached.

Submitter : GLADYS BELL **Date:** 09/12/2005

Organization : GLADYS BELL

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-886-Attach-1.DOC

Gladys Bell
5324 Mant Dr.
Santa Rosa, CA 95409

September 7, 2005

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

Re: GPCIs

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

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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.

Sincerely,

Gladys Bell
5324 Mant Dr.
Santa Rosa, CA 95409

cc: Two copies attached.

Submitter : JOAN BERGER **Date:** 09/12/2005

Organization : JOAN BERGER

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-887-Attach-1.DOC

CMS-1502-P-887-Attach-2.DOC

Joan Berger
370 Titlon Rd.
Sebastopol, CA 95472

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Joan Berger
370 Titlon Rd.
Sebastopol, CA 95472

cc: Two copies attached.

Submitter : MARCIA BERNIKER **Date:** 09/12/2005

Organization : MARCIA BERNIKER

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-888-Attach-1.DOC

Marcia Berniker
5429 Wilshire
Santa Rosa, CA 95404

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Marcia Berniker
5429 Wilshire
Santa Rosa, CA 95404

cc: Two copies attached.

Submitter : DENA BETTS **Date:** 09/12/2005

Organization : DENA BETTS

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-889-Attach-1.DOC

Dena Betts
15665 Norton Rd.
Healdsburg, CA 95448

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Dena Betts
15665 Norton Rd.
Healdsburg, CA 95448

cc: Two copies attached.

Submitter : MAE BEVAN **Date:** 09/12/2005

Organization : MAE BEVAN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-890-Attach-1.DOC

Submitter : ANN BINGHAM **Date:** 09/12/2005

Organization : ANN BINGHAM

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-891-Attach-1.DOC

Ann Bingham
7777 Bodega
Sebastopol, CA 95472

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Ann Bingham
7777 Bodega
Sebastopol, CA 95472

cc: Two copies attached.

Submitter : JACK BIRD
Organization : JACK BIRD
Category : Individual
Date: 09/12/2005

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-892-Attach-1.DOC

Jack Bird
710 S. Fitch Mountain Rd.
Healdsburg, CA 95448

September 7, 2005

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

Re: GPCIs

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Sincerely,

Jack Bird
710 S. Fitch Mountain Rd.
Healdsburg, CA 95448

cc: Two copies attached.

Submitter : JOHN BJORNSTROM
Organization : JOHN BJORNSTROM
Category : Individual
Date: 09/12/2005

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-893-Attach-1.DOC

CMS-1502-P-893-Attach-2.DOC

John Bjornstrom
4724 Woodview Dr.
Santa Rosa, CA 95405

September 7, 2005

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

Re: GPCIs

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

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Sincerely,

John Bjornstrom
4724 Woodview Dr.
Santa Rosa, CA 95405

cc: Two copies attached.

Submitter : ARIC BODIN
Organization : ARIC BODIN
Category : Individual

Date: 09/12/2005

Issue Areas/Comments

GENERAL

GENERAL
SEE ATTACHMENT

CMS-1502-P-894-Attach-1.DOC

Aric Bodin
7777 Bodega
Sebastopol, CA 95472

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Aric Bodin
7777 Bodega
Sebastopol, CA 95472

cc: Two copies attached.

Submitter : PHYLLIS BOGART
Organization : PHYLLIS BOGART
Category : Individual
Date: 09/12/2005

Issue Areas/Comments

GENERAL

GENERAL
SEE ATTACHMENT

CMS-1502-P-895-Attach-1.DOC

Phyllis Bogart
1801 Los Olivos Rd.
Santa Rosa, CA 95404

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Phyllis Bogart
1801 Los Olivos Rd.
Santa Rosa, CA 95404

cc: Two copies attached.

Submitter : PATRICIA BOHN

Date: 09/12/2005

Organization : PATRICIA BOHN

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-896-Attach-1.DOC

Patricia Bohn
5555 Rio Vida
Sebastopol, CA 95472

September 7, 2005

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

Re: GPCIs

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Sincerely,

Patricia Bohn
5555 Rio Vida
Sebastopol, CA 95472

cc: Two copies attached.

Submitter : ERNEST BONTA **Date:** 09/12/2005

Organization : ERNEST BONTA

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-897-Attach-1.DOC

Ernest Bonta
247 Oak Tree Dr.
Santa Rosa, CA 95401

September 7, 2005

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

Re: GPCIs

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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.

Sincerely,

Ernest Bonta
247 Oak Tree Dr.
Santa Rosa, CA 95401

cc: Two copies attached.

Submitter : MAUREEN BONTA **Date:** 09/12/2005

Organization : MAUREEN BONTA

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-898-Attach-1.DOC

Maureen Bonta
247 Oak Tree Dr.
Santa Rosa, CA 95401

September 7, 2005

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

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Sincerely,

Maureen Bonta
247 Oak Tree Dr.
Santa Rosa, CA 95401

cc: Two copies attached.

Submitter : ANNE BRADLEY **Date:** 09/12/2005

Organization : ANNE BRADLEY

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-899-Attach-1.DOC

CMS-1502-P-899-Attach-2.DOC

CMS-1502-P-899-Attach-3.DOC

Anne Bradley
7483 Applewood Rd.
Sebastopol, CA 95472

September 7, 2005

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

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Sincerely,

Anne Bradley
7483 Applewood Rd.
Sebastopol, CA 95472

cc: Two copies attached.

Submitter : FRANCIS BRADLEY **Date:** 09/12/2005

Organization : FRANCIS BRADLEY

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1502-P-900-Attach-1.DOC

Francis Bradley
7483 Applewood Ln.
Sebastopol, CA95472

September 7, 2005

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

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Sincerely,

Francis Bradley
7483 Applewood Ln.
Sebastopol, CA95472

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