Submitter : Mr. Gwen Morgan **Date:** 08/10/2007

Organization : West Texas Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Please See Attached Document

CMS-1385-P-5540-Attach-1.DOC

#3340

West Texas
PHYSICAL THERAPY

August 10, 2007

Re: CMS-1385-P

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Physician Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly patients in my community.

This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients' right to adequate and necessary medical care.

Sincerely,

Gwen Morgan, PT
West Texas Physical Therapy

Submitter : **Dr. Douglas Bell** **Date: 08/10/2007**

Organization : **Anesthesiology Associates of Wisconsin**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Douglas J. Bell, MD

Submitter : **Dr. Dean Roller** **Date: 08/10/2007**

Organization : **Dr. Dean Roller**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Miami,Fl I am writing to object to CMS s proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantifying the severity of these lesions. In particular, color Doppler information is critical to the decision making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Dean Roller, MD

Submitter : **Dr. George Vergara** **Date: 08/10/2007**

Organization : **Dr. George Vergara**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

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Sincerely yours,

George Vergara, MD

Submitter : Dr. Magdy Salama **Date:** 08/10/2007

Organization : Nashoba Valley Medical Center

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Ayer, Massachusetts as a solo, independent pathologist in a hospital.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from thc in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincercly,

Magdy M. Salama, MD

Submitter : **Dr. Yale Samole** **Date: 08/10/2007**

Organization : **Dr. Yale Samole**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

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Sincerely yours,

Yale Samoli, MD

Submitter : Dr. Matthew Snow **Date:** 08/10/2007

Organization : Dr. Matthew Snow

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

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Sincerely yours,

Matthew Snow, MD

Submitter : **Dr. Daniel Mecca** **Date: 08/10/2007**

Organization : **Dr. Daniel Mecca**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medieare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

Whcn the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician servicc s. Today, more than a decade since the RBRVS took effect, Medicarc payment for anesthcsia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Daniel Mecca, MD

Submitter : David Beardsworth, MD **Date:** 08/10/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 1, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to say thank you that CMS has recognized the under valuation of anesthesia services, and that the Agency is taking steps to address this complicated issue. I am writing to express my strongest support for the proposal to inerease anesthesia payments under the 2008 Physician Fee Schedule.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant under valuation of ancsthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia scrvices stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC rccommended that CMS increase the anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in an increase of nearly $4 per anesthesia unit, and serve as a major step forward in correcting the long-standing under valuation of anesthesia services.

To ensure that our senior patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase, as recommended by thc RUC. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

Thank you for your consideration.

David N. Beardsworth, MD
Northwest Anesthesia Physicians, P.C.

Submitter : Richard Finkelstein, MD **Date:** 08/10/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding– Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to thank CMS for recognizing the gross under valuation of anesthesia services, and the Agency's steps taken to address this complicated issue. I am writing to express my strongest support for the proposal to inerease anesthesia payments under the 2008 Physician Fee Schedule.

It has been 10 years since the RBRVS took effect, and today Medicare's payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our senior citizens, and is continuing to create an unsustainable system where anesthesiologists are being forced away from areas with disproportionately high Medicare populations. When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to the significant under valuation of anesthesia services, compared to other physician services.

In an effort to rectify this untenable situation, the RUC recommended that the CMS increase its anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in the increase of nearly $4 per anesthesia unit. This serves as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our senior patients will continue to have access to expert anesthesiology medical care, it is vital that CMS follow through with the proposal in the Federal Register, by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC.

Thank you for your consideration of this important matter.

Richard G. Finkelstein, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Mark Hibbard, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 27, 2007

Leslie V. Norwalk, Esq. Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)
Dear Ms. Norwalk:
Medicare payments for anesthesia services have been undervalued since the RBRVS system was created over 10 years ago. I am very happy to learn that the Agency is taking steps toward improving this situation. The very low payment by Medicare for anesthesia services has resulted in our best anesthesiologists choosing practice settings where they care for fewer Medicare patients.
In an effort to solve this problem, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32% work under valuation -- a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.
To ensure that our senior patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.
Thank you for your consideration of this serious matter.

Mark Hibbard, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Barbara Irving, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 27, 2007

Leslie V. Norwalk, Esq. Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)
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In an effort to solve this problem, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 % work under valuation-a move that would result in an increase of nearly $4. per anesthesia unit, and would serve as a major step forward to correct the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of RUC s recommendation.

To ensure that our senior patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Barbara Irving, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Ms. Patricia Cornwell** **Date: 08/10/2007**

Organization : **Palos Community Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Physical therapists cannot afford any more decreases in reimbursement. All expense are rising.

Submitter : **Dr. Thomas Englehart** **Date: 08/10/2007**

Organization : **Consultant Anesthesiologists Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Sincerely,

Thomas W. Englehart MD
Consultant Anesthesiologists Inc

Submitter : **Setiawan Kamaru, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 18, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Setiawan Kamaru DO
Northwest Anesthesia Physicians, P.C.

Submitter : Mark Krause, MD **Date:** 08/10/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 27, 2007

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Mark Krause, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Dr. Beth Ann Traylor** **Date: 08/10/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Dr. Beth Traylor

Submitter : **Gregg Melton, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 14, 2006

To Whom it May Concern:

I am writing to CMS to oppose the proposed changes in the Medicare Fee Schedule as a result of the recent five-year RVS review. These changes were published in the June 21st Federal Registry and Project a 10 percent cut in payment for anesthesia services over the next four years. As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the whole overhead cost increases for a handful of specialties. The proposed change hurts anesthesiology more than most specialties because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly under estimate actual expenses. The changes in CMS expenses do not reflect the increases we are currently incurring in costs such as liability and office personnel. The changes are a result of the continued zero sum rules of the RVS system. The payment in Eugene, Oregon for anesthesia services is 21 percent of our charges and 30 percent of what commercial carriers are providing. In fact, Medicaid pays 140 percent what Medicare does in this state. With these cuts, there will be less reason to continue to participate in Medicare. It is also obvious that these cuts create more cost shifting to private insurance to make up the losses for Medicare. This represents a hidden tax on the non-Medicare consumer of healthcare.

The AMA and ASA, for many years now, have attempted to work with Congress and CMS to address the sustained growth rate (SGR) formula which is inaccurate and creating a hardship for seniors in the access to healthcare. The medical payment system needs a major overhaul if physicians are to continue to participate in the Medicare program. If Congress and CMS fail to address the SGR, our nations most vulnerable population will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics and throughout critical care medicine. Copies of this letter will be sent to our representative members of Congress.

As a health care provider, I am concerned that these changes will have a negative impact on health care access and quality of care, both for the Medicare and non-Medicare patients.
Thank you for your time.

Sincerely,

Robb Nagata, M.D.
Northwest Anesthesia Physicians, P.C.

Submitter : Robb Nagata, MD **Date:** 08/10/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 14, 2006

To Whom it May Concern:

I am writing to CMS to oppose the proposed changes in the Medicare Fee Schedule as a result of the recent five-year RVS review. These changes were published in the June 21st Federal Registry and Project a 10 percent cut in payment for anesthesia services over the next four years. As the policy currently stands, anesthesiologists and other specialties face huge payment cuts to supplement the whole overhead cost increases for a handful of specialties. The proposed change hurts anesthesiology more than most specialties because the data that CMS uses to calculate overhead expenses is outdated and appears to significantly under estimate actual expenses. The changes in CMS expenses do not reflect the increases we are currently incurring in costs such as liability and office personnel. The changes are a result of the continued zero sum rules of the RVS system. The payment in Eugene, Oregon for anesthesia services is 21 percent of our charges and 30 percent of what commercial carriers are providing. In fact, Medicaid pays 140 percent what Medicare does in this state. With these cuts, there will be less reason to continue to participate in Medicare. It is also obvious that these cuts create more cost shifting to private insurance to make up the losses for Medicare. This represents a hidden tax on the non-Medicare consumer of healthcare.

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As a health care provider, I am concerned that these changes will have a negative impact on health care access and quality of care, both for the Medicare and non-Medicare patients.
Thank you for your time.

Sincerely,

Robb Nagata, M.D.
Northwest Anesthesia Physicians, P.C.

Submitter : Dr. Wayland Blikken **Date:** 08/10/2007

Organization : St. Mary's Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

We have been under a steady cuts now for the last decade plus. We are not going to be able to attract and retain talented anesthesiologists to take care of patient's and family members if congress doesn't act now. Please consider the proposed modest increase in anesthesiology reimbursement now.

Submitter : Dr. Joshua Harris **Date:** 08/10/2007

Organization : Dr. Joshua Harris

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

CODING ADDITIONAL CODES FROM 5-YEAR REVIEW. The federal register citation is 72 Federal Register 38122 (July 12, 2007).

Echo doppler with color flow is an essential component added to those echocardiograms which require further diagnostic interpretation for specialzed situations, specifically valvular diseases. Skilled sonographers and physicians take extra time to evaluate this useful diagnostic modality. It is an essential part of a skilled cardiology practice.

Thank you for your consideration of my comments.

Submitter : **Luat Nguyen, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 31, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross under valuation of anesthesia services, and the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant under valuation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work under valuation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our senior patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC.

Thank you for your consideration of this serious matter.

Luat Nguyen, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Brad Palmen, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to thank CMS for recognizing the gross under valuation of anesthesia services, and the Agency's steps taken to address this complicated issue. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

It has been 10 years since the RBRVS took effect, and today Medicare's payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our senior citizens, and is continuing to create an unsustainable system where anesthesiologists are being forced away from areas with disproportionately high Medicare populations. When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to the significant under valuation of anesthesia services, compared to other physician services.

In an effort to rectify this untenable situation, the RUC recommcnded that the CMS increase its anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in the increase of nearly $4 per anesthesia unit. This serves as a major step forward in correcting the long-standing under valuation of anesthesia services. 1 am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our senior patients will continue to have access to expert anesthesiology medical care, it is vital that CMS follow through with the proposal in the Federal Register, by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC.

Thank you for your consideration of this important matter.

Bradley D. Palmen, MD
Northwest Anesthesia Physicians, P.C.

Submitter : Albert Cho, MD **Date:** 08/10/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to thank CMS for recognizing the gross under valuation of anesthesia services, and the Agency's steps taken to address this complicated issue. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

It has been 10 years since the RBRVS took effect, and today Medicare's payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our senior citizens, and is continuing to create an unsustainable system where anesthesiologists are being forced away from areas with disproportionately high Medicare populations. When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to the significant under valuation of anesthesia services, compared to other physician services.

In an effort to rectify this untenable situation, the RUC recommended that the CMS increase its anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in the increase of nearly $4 per anesthesia unit. This serves as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our senior patients will continue to have access to expert anesthesiology medical care, it is vital that CMS follow through with the proposal in the Federal Register, by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC.

Thank you for your consideration of this important matter.

Bradley D. Palmen, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Kevin Dorf** **Date: 08/10/2007**

Organization : **Green Oaks PT**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Physician Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly and disabled patients in my community.

This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

In addition, the strain that a cut of 9.9% will put on a small practice like mine will be devestating. We are already dealing with decreased reimbursements from CMS and multiple other carriers. This trend may mean the end of many private practitioners and buisnesses who struggle to provide great care to our patients.

I understand that the AMA, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients right to adequate and necessary medical care.

Sincerely,

Submitter : **Barry Perlman, MD, PhD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 31, 2007

Leslie V. Norwalk, Esq. Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Anesthesia Coding (Part of 5-Year Reviciw)

Dear Ms. Norwalk:

I am writing in support of the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule -- CMS-1385-P.

Institution of RBRVS created a huge payment disparity for anesthesia care, as it significantly under valued anesthesia work compared to other physician services. As a result, Medicare payment for anesthesia services is currently just $16.19 per unit, an amount three to four times lower than payments from private insurers. This low Medicare value makes it difficult to recruit and retain anesthesiologists in areas with disproportionately high Medicare populations.

In addition, sustained decreases in reimbursement will make a career in anesthesia less attractive to future medical students, eventually compromising national access to high quality anesthesia care. Continued infusion of new anesthesiologists into the workforce and clinical research is vital for maintaining the excellent perioperative safety our patients currently enjoy.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our senior patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC.

Thank you for your consideration.

Sincerely,

Barry Perlman, PhD, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Dr. Neal Fleming** **Date: 08/10/2007**

Organization : **Dr. Neal Fleming**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Neal Fleming MD, PhD
Director, Cardiovascular and Thoracic Anesthesiology
UC Davis School of Medicine

Submitter : **Alex Raiskin, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 1, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P Anesthcsia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to say thank you that CMS has recognized the under valuation of anesthesia services, and that the Agency is taking steps to address this complicated issue. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant under valuation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untcnablc situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in an increase of nearly $4 per anesthesia unit, and serve as a major step forward in correcting the long-standing under valuation of anesthesia services.

To ensure that our senior patients havc access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the ancsthesia conversion factor increase, as recommended by the RUC. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

Thank you for your consideration.

Alex O. Raiskin, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Dr. Michael Robley** **Date: 08/10/2007**

Organization : **Dr. Michael Robley**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.
Dr. Michael robley

Submitter : **Brian Robinson, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 24, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms.Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the significant under valuation of anesthesia services, and the Agency is taking steps to address this issue. At Sacred Heart Medical Center, our combined Medicare and OHP population represents 50% of our business. At current Medicare rates, we receive < 20% of our billed charges.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant under valuation of anesthesia work compared to other physician services. I am also board certified in internal medicine so fully aware of the inequity in compensation for anesthesia services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation's seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations. Hospitals which serve high Medicare populations find it difficult to recruit highly qualified anesthesiologists to care for Medicare patients, who tend to be sicker and have higher acuity.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase anesthesia conversion factor to offset a calculated 32 percent work under valuation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

To ensure that our senior patients have access to expert anesthesiology medicare care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC. I am grateful that CMS has finally addressed this serious matter.

Thank you.

Brian Robinson, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Joyce Schlichting, MD, PhD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 31, 2007

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to express my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I want to thank CMS for recognizing the gross under valuation of anesthesia services, and steps the Agency is taking to address this complicated issue.

When the RBRVS was instituted it created a huge payment disparity for anesthesia care, mostly due to significant under valuation of anesthesia work, compared to other physician services. Today more than 10 years since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced to move away from our areas (Oregon) with disproportionately high Medicare populations.

In an effort to rectify this situation, the RUC recommended CMS increase the anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in an increase of nearly $4 per anesthesia unit, and serve as a major step forward to correct the long-standing under valuation of anesthesia services.

To ensure that our senior patients have access to expert anesthesiology medical care, it is imperative that
CMS follow through with the proposal in the Federal Register, by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for accepting this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

Joyce Schlichting, MD, PhD
Northwest Anesthesia Physicians, P.C.

Submitter : **Dr. marc gattiker** **Date: 08/10/2007**

Organization : **Dr. marc gattiker**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Ms Norwalk,

I would like to thank you for your time and considerations in supporting CMS-1385-p. I feel that it is essential to support this docket in order to ensure that our citizens have access to the best medical care / treatment options. Thanking you beforehand for all of your efforts on our behalf.

Sincerely,

Dr Marc Gattiker

Submitter : **Brian St. George, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 20, 2007

Leslie V. Norwalk, Esq., Aeting Administrator
Centers for Medicare and Medicaid Serviees
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

Thank you, CMS, for recognizing the gross under valuation of anesthesia services, and the Agency's steps taken to address this complicated issue. I am writing to express my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

Ten years ago, the RBRVS took effect, and today Medicare's payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our senior citizens, and is eontinuing to create an unsustainable system where anesthesiologists are being forced away from areas with disproportionately high Medicare populations. When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to the significant under valuation of anesthesia services, compared to other physician services.

In an effort to rectify this untenable situation, thc RUC recommended that the CMS increase its anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in the increase of nearly $4 per anesthesia unit. This serves as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

Overall, I see this as a first step toward rectifying Federal Medicare payments. As the system now stands, competition only exists for private insurance customers, while Medicare and Medicaid patients are left behind. Does this under valuation represent the government's overall under valuation of these vulnerable individuals to our American Society?

To ensure our senior patients will continue to have access to expert anesthesiology medical care, it is vital that CMS follow through with the proposal in the Federal Register, by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC. Thank you for considering this.

Brian St. George, MD
Norhtwest Anesthesia Physicians, P.C.

Submitter : Dr. Franklin Rosenberg **Date:** 08/10/2007

Organization : Woodland Anesthesiology Associates, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion faetor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Todd Tritch, MD **Date:** 08/10/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to thank CMS for recognizing the gross under valuation of anesthesia services, and the Agency's steps taken to address this complicated issue. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

It has been 10 years since the RBRVS took effect, and today Medicare's payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our senior citizens, and is continuing to create an unsustainable system where anesthesiologists are being forced away from areas with disproportionately high Medicare populations. When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to the significant under valuation of anesthesia services, compared to other physician services.

In an effort to rectify this untenable situation, the RUC recommended that the CMS increase its anesthesia conversion factor to offset a calculated 32 % work under valuation a move that would result in the increase of nearly $4 per anesthesia unit. This serves as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our senior patients will continue to have access to expert anesthesiology medical care, it is vital that CMS follow through with the proposal in the Federal Register, by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC.

Thank you for your consideration of this important matter.

Todd Tritch, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **James Whitmore, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This letter is to thank CMS for recognizing the gross under valuation of anesthesia services, and the Agency's steps taken to address this complicated issue. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

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Todd Tritch, MD
Northwest Anesthesia Physicians, P.C.

Submitter : Mr. William Carolus **Date:** 08/10/2007

Organization : American Society of Echocardiography

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

Echocardiography refers to an ultrasound examination of the heart. The examination can include information obtained from any one or more of the following different modalities i.e. 2-D or 2 dimensional, 3-D or 3 dimensional, M-mode or motion mode, color flow, pulsed wave doppler, continuous wave doppler which can be steerable or non-steerable... Each of these modalities requires increased time and effort on the part of both the sonographer and the interpreting M.D. It would be a mistake to presume color flow is integral to all exams or that it does not require increased time and effort when indicated and consequently employed. I encourage you to vote no on 'Bundling' of the modality - color flow - into Echocardiographic examinations when considering reimbursement changes.

Submitter : **Dr. Melissa Chiles** **Date: 08/10/2007**

Organization : **College of American Pathologists**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 10, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Knoxville, TN as part of a 14-member pathology group that operates an independent laboratory as well as provides hospital service to 3 of our major in-city hospitals as well as to several smaller entities in surrounding towns.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,

Melissa C. Chiles, M.D.

Submitter : **Ms. Donna White, RDCS** **Date: 08/10/2007**

Organization : **Cardiology Associates, Inc**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Wooonsocket,RI I am writing to object to CMS s proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an indepcndent consultant and submitted by the American College of Cardiology and the American Socicty of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, whieh were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years. [Include additional examples from your practice of CPT codes that are rarely billed with color flow Doppler.]

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Donna J. White,
Cardiology Associates, Inc.
Woonsocket, RI

Submitter : Mr. Jay Spracklen **Date:** 08/10/2007

Organization : Spracklen Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

ASP Issues

ASP Issues

This proposal will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly patients in my community. It will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care. The APTA, AOTA, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients' right to adequate and necessary medical care. Thank you.
Jay Spracklen, PT

Submitter : Dr. Krystyna Sikorska **Date:** 08/10/2007

Organization : New England Pathology Assoc

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Springfield, Massachusetts as part of a 6-member pathology practice in a hospital setting.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exeeption to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,
Krystyna Sikorska MD
New England Pathology Assoc.
Springfield, MA

Submitter : Dr. Jay Hockman **Date:** 08/10/2007

Organization : Dr. Jay Hockman

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS reimbursements are already unreasonably low for anesthesia services. A significant increase in the anesthesia reimbursement is crucial to the viability of the specialty and to ensure access to medicare/medicaid patients.

Thank You for your consideration.

Jay Hockman, M.D.

Submitter : **Dr. Steven Santolin** **Date: 08/10/2007**

Organization : **Santolin Chiropractic Clinic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring an X-ray the cost to the Medicare patient will go up significantly due to the necessity of a referral to an orthopedist or rheumatologist for evaluation prior to referral to the radiologist as it is now. With fixed incomes and limited resources, Medicare patients may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Steven Santolin, DC

Submitter : **Dr. Jay Hockman** **Date: 08/10/2007**

Organization : **Dr. Jay Hockman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Shirin Nash **Date:** 08/10/2007

Organization : New England Pathology Associates, PC

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 10, 2007

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Sineerely,

Shirin Nash, M.D.

Submitter : Dr. Gerald Nash **Date:** 08/10/2007

Organization : New England Pathology Associates, PC

Category : Physician

Issue Areas/Comments

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Sincerely,

Gerald Nash, M.D.

Submitter : Dr. Jeffrey Sussman **Date:** 08/10/2007

Organization : New England Pathology Associates, PC

Category : Physician

Issue Areas/Comments

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Sincerely,

Jeffrey Sussman, M.D.

Submitter : Mr. Martin Bur **Date:** 08/10/2007

Organization : New England Pathology Associates, PC

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

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Sincerely,

Martin Bur, M.D.

Submitter : Dr. Bruce Dziura **Date:** 08/10/2007

Organization : New England Pathology Associates, PC

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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Sincerely,

Bruce Dziura, M.D.

Submitter : Dr. Lee Ann Pearse **Date:** 08/10/2007

Organization : Dr. Lee Ann Pearse

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#5589

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

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

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

Submitter : Dr. Lee Ann Pearse **Date:** 08/10/2007

Organization : Dr. Lee Ann Pearse

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5590-Attach-1.PDF

#5590

August 8, 2007

PEDIATRIX MEDICAL GROUP

LEE ANN PEARSE, M.D.
Medical Director

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O.Box 8018
Baltimore, MD 21244-80188

Re: File Code: CMS-1385-P. CODING—ADDITIONAL CODES FROM 5-YEAR REVIEW

To Whom It May Concern:

I am writing you today to voice my concerns over the proposed change to the Medicare payment methodology for echocardiography services. My understanding is that CMS is proposing to bundle CPT 93325, which is Doppler Echocardiography Color Flow Velocity Mapping, with other CPT codes which include, but is not limited to, 93307 and 93303. Concomitantly, no proposed change is made to increase the RVUs in the bundled code.

While I appreciate the advances that have been made from a technical standpoint, which may expedite the ability of the technician to perform the study without changing the probes as frequently, for example, the interpretive value of the color Doppler supports its ability to stand alone. By this I mean that the information that is obtained from color Doppler is critical to the success of echocardiography in the setting of congenital heart disease, whether it is in the pediatric realm or the adult realm. Color Doppler is able to pick up small details that are missed by 2D and/or Doppler alone. Let me give you some examples. In the case of anomalous coronary artery disease, the coronaries may appear to arise properly from the aorta, but after color flow is added, one can see that the direction of flow is incorrect and the diagnosis can then be further evaluated by Doppler. This will not be necessarily seen with 2D alone and therefore, not automatically detected by Doppler. Small muscular VSDs are another example of things found with color but not necessarily by 2D and then confirmed with Doppler. A third example is anomalous pulmonary venous return. The 4 pulmonary veins may come to a confluence behind the left atrium and appear by 2D to enter the left atrium, only to find that by color the flow pattern is not consistent with the veins actually entering the left atrium. Again, the color exam then guides the Doppler evaluation to confirm the suspicions. A final example is in the case of stenotic valves. By 2D the pulmonary valve, for example, may look stenotic. Doppler interrogation will reveal a turbulent jet that gives rise to a gradient, which may or may not be an accurate assessment of the severity. However, with color flow, you are more likely to get the best jet to evaluate based on the color characteristics, thus giving more accurate data.

In summary, color flow Doppler is an integral component to the echocardiogram in the setting of congenital heart disease and should be viewed as a separate and necessary entity. I would encourage you to NOT implement the proposed changes and, if further changes are needed, that the nuances that make congenital heart disease evaluation and management be fully taken into account and those most involved with this be part of the discussion. Thank you for your attention to this matter.

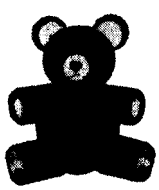
Respectfully yours,

Lee Ann Pearse, MD

Lee Ann Pearse, M.D.
Pediatric Cardiologist

Pediatric, Adult Congenital and Fetal Cardiology
7777 Forest Lane, Suite B-141
Dallas, TX 75230
972.566.5622 Fax: 972.566.5616
email: leeann_pearse@pediatrix.com

4401 N. Coit Road, Suite 313
Frisco, TX 75035



Submitter : **Dr. Timothy Smith** **Date: 08/10/2007**

Organization : **Dr. Timothy Smith**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Sincerely,

Timothy M. Smith, M.D.

Submitter : Dr. Craig Hollowell **Date:** 08/10/2007

Organization : Hollowell Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring an X-ray the cost to the Medicare patient will go up significantly due to the necessity of a referral to an orthopedist or rheumatologist for evaluation prior to referral to the radiologist as it is now. With fixed incomes and limited resources, Medicare patients may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Craig C. Hollowell, D.C.

Submitter : Richard Johnston, MD **Date:** 08/10/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 9, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P

Anesthesia Coding (Part of 5 year Review)

Dear Ms. Norwalk:

I am writing to express my strong support for the proposals to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross under valuation of anesthesia services compared to other physicians from the original Hsau study from the 80's and early 90's. It is important that CMS is taking steps to address this issue.

When the RBRVS was initiated, it created a huge payment disparity for anesthesia care, due to the under valuation of anesthesia work compared to other physicians. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This means in my local area of Eugene, Oregon, I am being paid less for twelve years of education post high school and a high risk occupation than the plumbers, electricians and automobile repair jobs. This current amount does not cover the cost of caring for our nation's seniors and has created an unsustainable system in which anesthesiologists are being forced away from areas with disproportionally high Medicare populations such as we have at Sacred Heart Medical Center in Eugene. Our Medicare and Medicaid percentage of patients is 52 percent. This has forced anesthesiologists to migrate to ambulatory surgery centers to care for non-Medicare, higher paying patients. This has reached a critical point and in some areas in the nation, hospitals are having difficulty staffing anesthesia departments without substantial subsidies.

In an effort to rectify this situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work under valuation. A $4.00 per anesthesia unit increase is an attempt to correct the long-standing under valuation. I am pleased that the agency accepted this recommendation in its proposed rule, and I fully support the implementation of the RUC's recommendation.

To ensure that Medicare patients have access to anesthesiology medical care, it is important that CMS follow through with the proposal in the Federal Register. I again express my support and encourage implementing the anesthesia conversion factor increase, as recommended by the RUC.

Sincerely,

Richard R. Johnston, MD
Northwest Anesthesia Physicians

Submitter : **John Jordan, MD** **Date: 08/10/2007**

Organization : **Northwest Anesthesia Physicians, P.C.**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 18, 2007

Leslie V. Norwalk, Esq. Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)
Dear Ms. Norwalk:
Medicare payments for anesthesia services have been undervalued since the RBRVS system was created. I am very happy to learn that the Agency is taking steps toward improving this situation. The very low payment by Medicare for anesthesia services has resulted in our best anesthesiologists choosing practice settings where they care for fewer Medicare patients.
In an effort to solve this problem, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work under valuation-a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing under valuation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.
To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.
Thank you for your consideration of this serious matter.

John S. Jordan, MD
Anesthesia Department Chief
Sacred Heart Medical Center
Eugene, Oregon

Submitter : Mrs. Linda Bolt **Date:** 08/10/2007

Organization : Macon Orthopaedic and Hand center

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I work in a physician practice and know for a fact that abuse does not occur in every setting. I do not see how CMS can target a certain type of practice when abuse can potentially occur in private practices, hospitals, etc. I belive it is a misconception that abuse occurs more in physician practices than other practices. We have a practice in which there is excellent communication between therapist and physician. Optimal outcomes can come from this type of setting. We are in a physician setting in which charges are not any more than in other type of settings. Money can actually be saved with this type of setting rather than abused. Our patients are happy because the physician setting is actually more convenient for them. They are familiar with the MD practice and staff. They can go to Therapy and see the MD on the same day which often saves them money and time. Our physicians really care about the outcomes of their surgeries. The reason that they have therapists on staff is so they can help control how soon the patient is seen and what the costs are. When they did not own the Therapy, appointments were not scheduled timely at the Hospital setting and the charges were higher. To target physician practices as the only practice that may practice abuse seems unjust. I think it is a misconception that the physician practices are trying to make more money than other settings. The physicians care about the patients and want a system in which the best services can be provided, accessibility of services is good and a system in which there is optimal communication to enhance the services provided to the patients. I hope that CMS will reconsider altering the Stark provisions. I feel that the target should be on those that you have audited and have shown abuse rather than on those that you just think may be abusing. I think there is a great misconception about the physician practices. I would not be working in this type of setting if it did not provide something ethical and unique for the patient and did not allow me to work towards optimal outcomes. Please consider my comments as they are sincere and passionate about the type of setting and type of treatment that I am personally allowed to render in a physician setting.

Submitter : **Dr. Donald Hall** **Date: 08/10/2007**

Organization : **Mid-Penn Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Vickie Varklet **Date:** 08/10/2007

Organization : Mid-Penn Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Brian Hopkins **Date:** 08/10/2007

Organization : Dr. Brian Hopkins

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#5598

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

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

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

Submitter : **Dr. Todd Burmeister** **Date: 08/10/2007**

Organization : **Dr. Todd Burmeister**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Todd Burmeister, D.O.

Submitter : **Dr. Kathy Schwock** **Date: 08/10/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk and CMS

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Kathy L. Schwock, MD
Georgia

Submitter : Dr. Harold Allen **Date:** 08/10/2007

Organization : Allen Chiropractic Health Clinic

Category : Chiropractor

Issue Areas/Comments

Background

Background

I have many Medacare patients on fixed or low income that cannot afford the expense of x-rays that helps rule out 'red flags' that could be presant even though I use the P.A.R.T to determine the subluxation. This allows me as a Chiropractic physician make a proper diagnosis and determine the proper treatment. Allowing the doctor of Chiropractie to send these patients directly to a radiologist for the x-ray service, eliminates a time delay in treatment and incresed cost of a referral to another provider (family docotor, orthopedist etc.)

Eliminating this service places an unnecessary burden on the Medacare patients that need chiropractic care.

Submitter : Dr. Scott Berger **Date:** 08/10/2007

Organization : Colorado Permanente Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#5602

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

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

Submitter : **Dr. John Rubbo** **Date: 08/10/2007**

Organization : **Southern Arizona Anesthesia Services PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely, John T. Rubbo M.D.

Submitter : **Eric Barrett** **Date: 08/10/2007**

Organization : **UMC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Hatai Sinthusek **Date:** 08/10/2007

Organization : Dr. Hatai Sinthusek

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Tina Kovel **Date:** 08/10/2007

Organization : Tina Kovel

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring an X-ray the cost to the Medicare patient will go up significantly due to the necessity of a referral to an orthopedist or rheumatologist for evaluation prior to referral to the radiologist as it is now. With fixed incomes and limited resources, Medicare patients may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely, Tina Kovel

Submitter : **Howard Rogers** **Date: 08/10/2007**

Organization : **Howard Rogers**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Howard L. Rogers

Submitter : **Ana Chamberlain** **Date: 08/11/2007**

Organization : **Ana Chamberlain**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

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I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Ana Chamberlain

Submitter : **Dr. Brett Wilkerson** **Date: 08/11/2007**

Organization : **Dr. Brett Wilkerson**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Sincerely,

Brett Wilkerson M.D.
Chairman Department of Anesthesia
OSF St. Francis Medical Center
Peoria, IL

Submitter : **Dr. Ronald Robinson** **Date: 08/11/2007**

Organization : **High Plains Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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