Submitter : **Mr. harshad gurnaney** **Date: 08/16/2007**

Organization : **chop**

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 increasc anesthesia payments under the 2008 Physician Fee Schcdulc. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agcncy is taking steps to address this complicated issue.

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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.

CMS-1385-P-6059-Attach-1.DOC

#1059

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 : MeLynn Pattillo **Date:** 08/16/2007

Organization : RJP Southwest, Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please do not cut our reimbursement again. A 9.9% cut will deal a fatal blow to most outpatient rehabiliation clinics. We will not be able to continue as a Medicare Provider should this cut in reimbursement go through. MeLynn L. Pattillo, Vice President, Asst. Adminstrator, RJP Southwest, Inc. dba Alamogordo Physical Therapy. We also co-own Artesia Physical Therapy, LLC and Carlsbad Physical Therapy, LLC.

Submitter : Ms. Matthew Spiegelman, MPT **Date:** 08/16/2007

Organization : Brooklyn BodyWorks Physical Therapy, PC

Category : Physical Therapist

Issue Areas/Comments

CAP Issues

CAP Issues

I am a physical therapist in private practice who is struggling to maintain a high level of quality care in my practice. I am struggling to understand how lowering physician fee schedules and instituting a cap on physical therapy services is justifiable when all consumer goods and services are more expensive everyday. We need to keep up with inflatiion and raise reimbursements for physicians.

Submitter : **Dr. William Beppu** **Date: 08/16/2007**

Organization : **Olympia Anesthesia Associates, P.C.**

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.

Submitter : **Robert Gray** **Date: 08/16/2007**

Organization : **Robert Gray**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Date: August 16, 2007

To: Centers for Medicare and Medicaid Services

From: Robert G. Gray, Physical Therapist

Re: Stark Phase II comments

I would like to offer comment on the interim final rule regarding Physicians Referrals to Health Care Entities With Which They Have Financial Relationships . I respectfully implore CMS to address these issues as part of possible Phase III regulations.

The potential for abuse and occasionally fraud exists when physicians are allowed to refer patients of any payor type, including Medicare and Medicaid, to an entity in which they have a financial interest. This situation is further complicated by Medicare s requirement that beneficiaries receive a physician referral prior to initiating therapy treatments. Physicians who own practices that provide therapy services undoubtedly have a financial incentive to refer patients to those practices in which they are vested and in many instances those services are overutilized for financial reasons.

I am a Physical Therapist with 21 years experience in Midland, Texas where I have been self-employed in private practice for the past 16 years. During this time, I have provided therapy services to the patients of many of the local orthopedic surgeons. That is about to change as the local orthopedists are forming a large group practice in which they will have their own in-house Physical Therapy clinic, owned by the group of orthopedists. Of course, their referrals to me will cease as they now have a financial incentive to refer entirely to the clinic they own.

The situation that is about to occur will:

- allow potential for abusive referrals, as the referring physicians will own the clinic to which they refer beneficiaries

- negate the choice of the beneficiary to have services provided from whom they would choose

- significantly effect the continuation of my business and its provision of quality services to those in need of Physical Therapy as each and every patient seen in my clinic is treated each and every visit by a licensed Physical Therapist

- allow beneficiaries to be treated by non-professional personnel, as the physician clinic employees several athletic trainers who see patients for whom Physical Therapy is ordered, without the patient actually being treated by a licensed Physical Therapist (this is a quality of care issue)

Much of this could be avoided if CMS would re-address and eliminate the loophole created with the in-offices ancillary services which is so broadly defined that it encourages the creation of abusive referral arrangements. There is no doubt that the loophole has created a captive referral base for these physicians and others across the country. The loophole also facilitates the use of non-professional personnel, who by no means have the education necessary to provide therapy services, to do so at a detriment to the beneficiary, which could be very harmful to the patient.

I appreciate you allowing me to provide comment and would be happy to discuss my comments or answer any questions you may have.

Sincerely,

Robert G. Gray, PT

P.O. Box 80700
Midland, TX 79708

432-570-7850

#6063

Date: August 16, 2007

To: Centers for Medicare and Medicaid Services

From: Robert G. Gray, Physical Therapist

Re: Stark Phase II comments

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Sincerely,

Robert G. Gray, PT

P.O. Box 80700
Midland, TX 79708

432-570-7850

CMS-1385-P-6063-Attach-1.DOC

Submitter : **Dr. Howard Leibowitz** **Date: 08/16/2007**

Organization : **Sheridan Healthcorp**

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.

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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,
Howard Leibowitz, MD
Anesthesiologist

Submitter : **Patrick Solomon** **Date: 08/16/2007**

Organization : **Patrick Solomon**

Category : **Individual**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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:

The payment for Medicare anesthesia services is inadequate. This has led to hospitals subsidizing the anesthesiologists as well as a shortage of anesthesia services at hospitals with high medicare populations.

Increasing the fee probably won't increase anesthesiologists compensation much. It will just allow other parties to not subsidize the service as much, thereby bringing balance to payment systems.

Patrick Solomon

Submitter : Dr. Andrew Vu **Date:** 08/16/2007

Organization : University of Tennessee

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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.

Submitter : **Ronald Malanowski** **Date: 08/16/2007**

Organization : **Ronald Malanowski**

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

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Thank you for your consideration of this serious matter.

Ronald Malanowski
8641 NW 57 Ct
Coral Springs, FL 33067

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

Physicians demanding patients go to their PT practices is truly hurting our profession and costing insurance a lot of money.

I had a patient last year who came to me for a pretty straight forward shoulder impingement syndrome. His prescription for PT said 3 visits then discharge to a home exercise program. When he handed me the prescription, he said my doctor originally gave me a prescription for 3 times a week for 6 weeks and told me to go make an appointment at his PT clinic next door. When I said I am going to return the PT who I had used before, he took the script out of my hand, ripped it up and wrote out this new one for 3 visits only.

More recently I had a patient who didn t show up for her appointments after a re-evaluation the following week. When I called the patient, she said that the doctor now has his own PT and said I will not write you a script to go to any other PT place. You need to come here where I can keep an eye on you. He is in the building at most once a month and the patient really wanted to return to us but was not allowed. She was forced drive farther to his place in the middle of her rehab for major surgery.

Please remove physical therapy from the "in-office ancillary services" exception to the federal physician self-referral laws.

Thank you.

Submitter : Jerry Robderts **Date:** 08/16/2007

Organization : Dean Health System

Category : Health Care Provider/Association

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

While we fully support the idea of converting from fax to EDI transmissions (a la SureScripts or RxHub), we do not thing the proposed deadline is feasible. We suggest moving the deadline back by a year but keeping the rest of the proposal intact. There is simply too much work involved at a time when we are very busy implementing electronic medical records and complying with a number of other mandates. Perhaps more importantly, our vendors and our trading partners will likely not be ready in time either.

Submitter : Dr. Sher-Lu Pai **Date:** 08/16/2007

Organization : UT Southwestern

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Kenneth Richman** **Date: 08/16/2007**

Organization : **Pennsylvania Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Attention: CMS-1385-P

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,

(Your signature, name, and address)

PSA 777 East Park Drive

Harrisburg, PA 17111

Submitter : **Dr. Constantine Pappas** **Date: 08/16/2007**

Organization : **Hallmark Pathology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 16, 2007

Dear Sir or Madam:

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 Physicians Fee Schedule for Calendar Year 2008". I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Medford, Massachusetts as part of a six member hospital-based pathology group.

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 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 purchase 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 servies 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 aer 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 compromised the integrity of the Medicare program.

Sincerely,

C. Dean Pappas, MD
Chief of Pathology
Hallmark Health System
170 Governors Avenue
Medford, MA 02155

Submitter : Dr. Jose G. Figueroa **Date:** 08/16/2007

Organization : Anesthesiologist

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See attachment"

CMS-1385-P-6073-Attach-1.WPD

CMS-1385-P-6073-Attach-2.WPD

#6073

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.

Jose G. Figueroa, M.D.

Submitter : **Dr. Adel Younoszai** **Date: 08/16/2007**

Organization : **The University of Colorado**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am writing to you regarding the proposed change to bundle CPT codes for color Doppler interpretation of an echocardiogram with other pediatric echo related codes. I strongly disagree with this approach, especially as there is no increased re-imbursement for the new bundled codes proposed.
In my practice the use and interpretation of color Doppler has added significant value to echocardiography. Color Doppler adds significant value to a basic two dimensional scan, but does require some extra time to perform and significantly more time and effort to interpret. In addition, with the progress in new technology we are seeing color Doppler signals that were not possible to review before making interpretation even more challenging and time consuming. It does not seem logical to have a modality add complexity and time to interpretation but at the same time decrease re-imbursement.
I am a pediatric echocardiographer and I also have significant concerns regarding the implications of this change, based mainly on data from adult echocardiography, on my practice. The use of color Doppler in the neonate with complex heart disease is even more complex and can primarily drive management of these patients. Specific examples would be the directionality and flow velocities of children with intra and extra cardiac shunts, especially in the setting of pulmonary hypertension. Our commitment to the echocardiographic evaluation of color flow across these shunts often determines the need for surgery. "Flattening" this functionality into a two-dimensional echocardiogram, in essence taking away its value, is counter intuitive.
I have concern with the process as I have been informed. My understanding is that the CPT editorial panel did not recommend that color Doppler (93325) be bundled with all of the CPT codes that are currently proposed. I am also concerned that the implications on the pediatric cardiologist and therefore our care of children have, once again, been inadequately evaluated. Too many times in the past changes have been made on re-imbursement based solely on adult data that has a direct affect on our ability to care for children and the deleterious effects are only recognized after the fact, sometimes taking years to repair. In the meantime the pediatric specialist and their patients must suffer until appropriate perspective is obtained.
In summary, as a physician who specializes in pediatric echocardiography I am concerned that this proposed change, if implemented would negatively impact access to care for children. Pediatric cardiology programs have always provided care to insured and uninsured alike - we have not turned children away. However, if these changes are implemented affecting re-imbursement across the board, it is likely to significantly impact our ability to do so in the future.
I strongly urge CMS to withdraw the proposed changes with respect to bundling 93325 with other pediatric cardiology echocardiography codes until a more appropriate and targeted review of all related issues can be performed.

Thank you for your time and consideration.

Sincerely,

Adel K. Younoszai, MD
Director of Cardiac Imaging
The Children's Hospital
Denver, Colorado

Submitter : **Dr. reed shnider** **Date: 08/16/2007**

Organization : **cardiology associates**

Category : **Individual**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

this would unfairly reduce reembursement for doppler echo studies by assuming that doppler is integral to all echo studies . Doppler is related but distinct ,requires time and interpretation that should be appropriately recognised. This is a thinnly vealed attempt to reduce costs unfairly

Submitter : **Dr. Steven Stein** **Date: 08/16/2007**

Organization : **Dr. Steven Stein**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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. Hansa Mehta** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

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. Dennis Metaxas** **Date: 08/16/2007**

Organization : **Advanced REvenue Management**

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.

Submitter : **Mr. Robert Schmieg** **Date: 08/16/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburscs for anesthesia scrvices at approximately 40% of private market rates.
Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, cffective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Robert D. Schmieg CRNA, MS
1504 8th Street NE
Staples, MN 56479

Submitter : **Dr. Fernando Montoya** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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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 : **Dr. Anil Nath** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
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Thank you for your consideration of this serious matter.

Submitter : Dr. Marc Filstein **Date:** 08/16/2007

Organization : The Reading Hospital and Medical Center

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 16, 2007

Dear Sir/Madam:

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 Reading, Pennsylvania as part of a 9-member pathology group employed by the Reading Hospital and Medical Center.

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,
Marc R. Filstein, MD MS
Staff Pathologist

Submitter : **Dr. Todd Nelson** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

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
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Thank you for your consideration of this serious matter.

Submitter : Ms. Mary Veale **Date:** 08/16/2007

Organization : Bartlett Regional Hospital

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please eliminate physicians self referral to PT's in their office. This is very frusterating. Some (not all) physicians abuse this and do not follow the rules. They should not be allowed to profit from their referrals because it is abused, they send them more frequently, especially patients with good insurance, they do not offer the choice of therapist to patients (they say, "We can keep a closer eye on you if you come to therapy here"). The patients do not want to file a complaint because they do not want to make their physician angry.

Please remove physical therapy from the "in-office ancillary services" exception.

Thank you,
Mary Veale, PT
Hospital Rehabilitation Services Manager

Submitter : Mr. Michael Lanaghan **Date:** 08/16/2007

Organization : Care Advantage Rehabilitation

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would encourage CMS to reconsider having physical therapy services included in the services that allow in-office ancillary services for physicians to bill patients. I am a self employed physical therapist and an environment when the physician can profit from the referral is unethical at best and not needed at the least. I am glad that the area that I provide care in does not have any physician owned clinics and I hope that it stays that way. It would be difficult to impossible to compete against a clinic owned by the physicians. There are ample numbers of physical therapist providing care now and to use the argument that there was a shortage of PT's is no longer justified. I compete against clinics that are owned by the non-profit hospital and it is difficult enough with the hospital encouraging preference for their own clinic I am sure it would be worse if the physicians owned the clinic. Kick backs are illegal for a reason and this is just a subtle way for someone to make a profit by making a referral. Thank You for taking comments on this topic. Mike Lanaghan PT

Submitter : Dr. Dy Tien Nguyen **Date:** 08/16/2007

Organization : Advanced REvenue Managment

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.

Submitter : **Dr. Hanh Nguyen** **Date: 08/16/2007**

Organization : **Advanced rEvenue Managment**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Timothy Osborn** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Medicare Beneficiaries and commercial insurance members have been categorized as profit generators by physicians where the ability to selectively self-refer a generous paying insured to one's practice while relegating other non profit generating insured presents a compelling reason for spiraling health care costs. It is anticompetitive, monopolizing and cherry picking insured members for the exclusive and exhaustive point of what money managers call "positive carry" - the condition in which the cost of financing an investment is less than the return obtained from it. Therefore the investment is worth maintaining a position in. Having a stream of income without exception is only advantageous for one, beneficial to none and ultimately detrimental to all.

Speaking from experience in a hospital based outpatient setting, the effects of such categorization and conscious discrimination begin to erode outcomes in care as only the most complicated and involved clients are seen in the hospital clinics.

With respect to federal payor reimbursement, the inherent conflict of self-incentive interests begin over utilize physician office physical therapy and massively over reimburse usual and customary episodes of care. Since funding is from one federal body, a siphoning of funds from one source affects all.

Please consider enforcing with consequences the physician self-referral provisions...for the longevity of our health care system.

Submitter : Ms. Elise Hartenstein **Date:** 08/16/2007

Organization : Alamogordo Physical Therapy RJP Southwest

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am against the proposed 9.9% reduction to the 2008 fee schedule. Please stop this proposed cut.

Submitter : **Dr. CArol Pearson** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Araba Quansah** **Date: 08/16/2007**

Organization : **Advanced revenue Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : **Dr. Olivia Quintos** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
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Submitter : **Dr. Edward Ramsey** **Date: 08/16/2007**

Organization : **Advanced Revenue management**

Category : **Physician**

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Acting Administrator
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Submitter : **Dr. Roger Rankin** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : Won Ro **Date:** 08/16/2007

Organization : Advanced Revenue Management

Category : Physician

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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. Carlos Romero** **Date: 08/16/2007**

Organization : **Advanced REvenue Management**

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.

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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 : Mrs. cheryl a shoop **Date:** 08/16/2007

Organization : medflight of ohio

Category : Other Practitioner

Issue Areas/Comments

Ambulance Services

Ambulance Services

I am responding to the proposed revision to the payment policy of ambulance services under ambulance fee schedule for CY2008. The proposed rule is intended to create a specific exception to the beneficiary signature requirement for emergent ambulance services. The AAA believes strongly that the proposed rule would have the unintended effect of increasing the administrative and compliance burden on the ambulance service providers and suppliers as well as hospitals.We urge CMS to abandon this approach and to instead eliminate entirely the beneficiary signature requirement for all ambulance services.

Submitter : **Dr. Phyllis Steer** **Date: 08/16/2007**

Organization : **Anesthesiology Chartered**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:
This letter is to let you know that I support the proposed increase in anesthesia payments under the 2008 Physician Fee Schedule. I am pleased that the 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.
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Thank you for your consideration of this serious matter.
Sincerely,

Phyllis L. Steer, M.D.
Chief Of Anesthesiology/Medical Director
Heart of America Surgery Center
8935 State Avenue
Kansas City, KS 66112

Submitter : **Dr. George Skaria** **Date: 08/16/2007**

Organization : **Advanced Revenue Management**

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.

Submitter : Dr. ANDREW PHAM **Date:** 08/16/2007

Organization : WELLNESS CLINIC

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

IT IS VERY NECESSARY FOR THE MEDICARE PATIENTS TO BE DIAGNOSED BY X-RAY DIRECTLY AT THEIR CHIROPRACTIC CLINICS. THE DOCTOR OF CHIROPRACTIC MAY KNOW ANY CONTRAINDICATION (RED FLAGS)APPEARING ON X-RAY. SO IT'S SAFER FOR THE PATIENTS. THEY DO NOT NEED TO BE REFERRED BACK TO MD OR ORTHOPEDIC FOR JUST X-RAY IMAGES. THEREFORE, WE SAVE A LOT OF MONEY FOR MEDICARE.
WE REQUEST OUR SENATORS AND REPRESENTATIVES TO HELP IN THIS MATTER.

THANK YOU VERY MUCH

DR ANDREW PHAM, D.C.

HOUSTON, TEXAS

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#610

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. Jordan Knurr** **Date: 08/16/2007**

Organization : **Dr. Jordan Knurr**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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. Edwin Regen** **Date: 08/16/2007**

Organization : **MMC Anesthesia Group, 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

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Thank you for your consideration of this serious matter.

E. Scott Regen, M.D.

Submitter : **Dr. Bassam Hammudi** **Date: 08/16/2007**

Organization : **MMC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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 : Amy Tseng **Date:** 08/16/2007

Organization : Bio-Tissue, Inc.

Category : Private Industry

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We request that HCPCS Level II Code V2790 be included in the CY 2008 PFS with a status indicator of "C" to permit payment for this code on an individual basis following a review of applicable documentation.

CMS-1385-P-6106-Attach-1.DOC

#6106

BIO-TISSUE

August 16, 2008

BY ELECTRONIC FILING AND OVERNIGHT MAIL

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05,
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (CMS-1385-P)

Dear Ms. Norwalk:

Bio-Tissue, Inc. ("Bio-Tissue") is pleased to submit the following comments on the Proposed Revisions to Payment Policies Under the Physician Fee Schedule ("PFS") for Calendar Year ("CY") 2008 (the "Proposed Rule"), 72 Fed. Reg. 38122 (July 12, 2007).

Bio-Tissue is a bio-tech company specializing in the discovery and manufacture of high quality amnion-based tissue and cell products that provide healing and regeneration of ocular surface tissue including the cornea and the conjunctiva. Bio-Tissue's current products, AMNIOGRAFT® and PROKERA™ , are used worldwide to help ophthalmologists treat conditions with ocular surface damage such as pterygium, corneal defects/ulcers, tumors/scars, viral infections, leaking glaucoma blebs, chemical burns, Stevens-Johnson Syndrome, high-risk corneal transplants, conjunctivochalasis, and many other conditions.

The Proposed Rule does not list preserved human amniotic membrane tissue (HCPCS Level II Code V2790) as a separately payable code. The medical products represented by code V2790, and in particular PROKERA™ , are well suited for use in a physician's office and have been so used to successfully treat a number of ocular injuries and diseases as discussed more fully below. When PROKERA™ is used in an office setting it would typically be billed with an E&M code for office related visits/treatments or possibly CPT 65780, the code for amniotic membrane transplantation. In either case, the cost of providing the amniotic membrane is not covered by existing codes. By failing to list V2790 in the PFS, the Centers for Medicare & Medicaid Services ("CMS") will create a significant disincentive for the use of amniotic membrane tissue in the treatment of ocular surface injury and disease. Furthermore, failure to list V2790 as a separately payable code in the PFS will cause providers and beneficiaries to seek alternative treatments that are often more expensive to the

7000 SW 97th Avenue, Suite 211, Miami, FL 33173 • V: 305-412-4430 • F: 305-412-4429 • E: info@biotissue.com

Medicare program, such as corneal transplant, and resort to surgical treatments in a more intensive settings, such as a hospital outpatient department or an ambulatory surgery center ("ASC").

In summary, we request that HCPCS Level II Code V2790 be included in the CY 2008 PFS with a status indicator of "C" to permit payment for this code on an individual basis following a review of applicable documentation.

Preserved Human Amniotic Membrane Tissue

Amniotic membrane is a safe, effective and therapeutic treatment option for corneal and conjunctival epithelial damage resulting from trauma or disease. Amniotic membrane is the inner most lining of the placenta which has been FDA recognized for the use in ocular surface wound repair and wound healing since 2001. The clinical efficacy of amniotic membrane transplantation for ocular surface reconstruction is well established in peer-reviewed scientific journals.

Clinical Office Use of Amniotic Membrane

Unlike eye shields, bandage contact lenses, patches and other eye protection options available for use in the office, amniotic membrane protects the ocular surface while simultaneously delivering therapeutic biologic actions that aid in ocular surface wound repair and wound healing. An ocular surface protected by amniotic membrane is simultaneously receiving amniotic membrane's FDA confirmed biologic actions which reduce inflammation, minimize scarring, facilitate epithelial wound healing, and aid in the migration of limbal stem cells.

The use of amniotic membrane in the office can prevent the need for a hospital or ASC procedure. Non-healing corneal defects that often lead to the need for corneal transplantation can be healed in the office using PROKERA™ . Patients that have had corneal transplants and run the risk of rejecting the transplant can be treated with PROKERA™ to help save the transplanted cornea. In addition, patients with acute chemical or thermal burns affecting their eyes can be treated immediately in the office with PROKERA™ and often do not require additional surgical procedures.

PROKERA™ Amniotic Membrane Device

PROKERA™ is an ophthalmic conformer containing amniotic membrane that is used to assist in ocular surface corneal and limbal wound repair and wound healing. PROKERA™ is constructed with two polycarbonate rings clipped together with a piece of amniotic membrane fastened in between. PROKERA™ can be easily inserted between the eyeball and the eyelid in the office.

The natural biologic actions of the amniotic membrane in PROKERA™ facilitate the healing process for the corneal and limbal surfaces. The polycarbonate rings are removed in the office once the ocular surface healing has taken place. No other commercially available product provides the same therapeutic actions as PROKERA in the office setting.

In October of 2006, CMS extended the supply code for preserved human amniotic membrane tissue, V2790, to include PROKERA™ . Without reimbursement for this device in the office setting, physicians will treat patients with corneal epithelial defects in the hospital or ASC where this device is

The leader in ocular surface tissue therapies.

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reimbursed. These alternative settings needlessly increase the cost of treatment and inconvenience the patient.

Given the substantial benefits offered by PROKERA™ when applied in an office setting, we ask that you carefully consider the significant applications of preserved amniotic membrane tissue, as well as the considerable impact amniotic membrane tissue can have on Medicare beneficiaries who exhibit the appropriate indications for its use.

Sincerely,

Amy Tseng

Amy Tseng, MBA
President

cc: Pam West, CMS
Cherie McNett, Director of Health Policy, American Academy of Ophthalmology
Gail Daubert, Esq.
Paul Pitts, Esq.

The leader in ocular surface tissue therapies.

7000 SW 97th Avenue, Suite 211, Miami, FL 33173 • V: 305-412-4430 • F: 305-412-4429 • E: info@biotissue.com

Submitter : **Dr. Louis Boxer** **Date: 08/16/2007**

Organization : **Pennsylvania 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 Rev iew)

Dear Ms. Norwalk:

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

When the RBRVS was instituted, it created a huge payment disparity for anesthesia eare, 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.

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Thank you for your consideration of this serious matter.

Sincerely,

Louis M. Boxer, M.D.
701 East Marshall Street
West Chester, PA 19380

Submitter : Dr. Glenn Gollobin **Date:** 08/16/2007

Organization : Anesthesia Associates of Cincinnati

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-6108-Attach-1.DOC

#6108

August 16, 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 an anesthesiologist practicing at the Christ Hospital in Cincinnati. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. It is gratifying 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 is less than one third the rate paid by commercial insurers. 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.

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Thank you for your consideration of this serious matter.

Glenn S Gollobin MD h: 513-321-4402
3514 Bayard Drive w: 513-585-2422
Cincinnati, OH 45208

Submitter : **Dr. James Bates** **Date: 08/16/2007**

Organization : **University of Iowa**

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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Thank you for your consideration of this serious matter.

Submitter : **Dr. Brad Davis** **Date: 08/16/2007**

Organization : **Dr. Brad Davis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Brad Richard Davis, MD

Submitter : **Dr. Stephanie Jacobs** **Date: 08/16/2007**

Organization : **Cardiology Associates**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

To Whom It May Concern:

I am a cardiologist practicing at Cardiology Associates, P.C., the largest and most comprehensive provider of cardiovascular care in the Nation s Capital and the adjacent Maryland suburbs. Our practice has been delivering state-of-the-art care since our founding in 1979, and we have continuously strived to provide the most technologically advanced diagnostics for our patients. I believe that the proposal to bundle reimbursement for color flow Doppler into the basic echocardiography examination is seriously misguided.

Historically color flow Doppler has provided significant additional information above that provided by 2D echo and Doppler technology alone. It traditionally has aided in the assessment of valvular lesions, directionality of cardiac flow, and was originally intended to visually quantify blood flow velocity in the heart and vascular systems. In recent years however, the use of Color Doppler in the assessment of cardiovascular abnormalities has become more complex and provides new and evolving tools for the noninvasive cardiologist. Now more than ever, it is being used to improve the assessment of more cardiovascular abnormalities seen on echo. The technology for the assessment of diastolic dysfunction is rapidly progressing and color flow mitral propagation velocity is just one example of a valuable, newer technique which requires specialized technologist training to perform and sub-specialized non-invasive cardiology training to interpret. PISA (proximal isovelocity surface area) is another example critical to the quantification of regurgitant and stenotic lesions. Obtaining accurate images is extremely operator dependent and requires extensive technologist training to perform these measurements accurately. It also requires additional training for those physicians who wish to interpret and utilize these results properly. Color Doppler has moved beyond simple visual analysis of regurgitation. This technology requires complex caleulations from fluid dynamie equations, and a thorough understanding of it benefits and limitations to be used accurately.

For this reason, it is imperative that Doppler technology be a separate entity that physicians can rely on as we advance our ultrasound technology to aid in the correct diagnosis and management of cardiac diseases. As these subspecialty technologies evolve, physicians and technicians alike, must continue to learn new skills, and elevate their level of training to match these advances. The fact that national CME courses exist in Echocardiography specifically designed to teach practicing cardiologists out of fellowship this technology speaks to the importance of this rapidly evolving field. The fact that ultrasound tcchnicians also require specialized training to perform these examinations further confirms that color flow Doppler represents a distinct and valuable diagnostic entity.

Based on the aforementioned facts, I believe it is critical that color Doppler not be bundled with 2D echo reimbursement. It is a technology that requires additional training and expertise to perform and interpret and since it is not used in every study, and will not be part of the standard exam, it should continue to be reimbursed as a separate additional procedure that enhances the diagnostic utility of the basic echocardiographic exam.

Please feel free to contact me if I can provide any further clarification. Thank you for your consideration

Sincerely,
Stephanie Jacobs, MD

Submitter : **Dr. Lawrence Jacobs** **Date: 08/16/2007**

Organization : **Cardiology Associates**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

CODING ADDITIONAL CODES FROM 5-YEAR REVIEW. The federal register citation is 72 Federal Register 38122 (July 12, 2007).
August 16, 2007

To Whom It May Concern:

I am a cardiologist practicing at Cardiology Associates, P.C., the largest and most comprehensive provider of cardiovascular care in the Nation s Capital and the adjacent Maryland suburbs. Our practice has been delivering state-of-the-art care since our founding in 1979, and we have continuously strived to provide the most technologically advanced diagnostics for our patients. I believe that the proposal to bundle reimbursement for color flow Doppler into the basic echocardiography examination is seriously misguided.

Historically color flow Doppler has provided significant additional information above that provided by 2D echo and Doppler technology alone. It traditionally has aided in the assessment of valvular lesions, directionality of cardiac flow, and was originally intended to visually quantify blood flow velocity in the heart and vascular systems. In recent years however, the use of Color Doppler in the assessment of cardiovascular abnormalities has become more complex and provides new and evolving tools for the noninvasive cardiologist. Now more than ever, it is being used to improve the assessment of more cardiovascular abnormalities seen on echo. The technology for the assessment of diastolic dysfunction is rapidly progressing and color flow mitral propagation velocity is just one example of a valuable, newer technique which requires specialized technologist training to perform and sub-specialized non-invasive cardiology training to interpret. PISA (proximal isovelocity surface area) is another example critical to the quantification of regurgitant and stenotic lesions. Obtaining accurate images is extremely operator dependent and requires extensive technologist training to perform these measurements accurately. It also requires additional training for those physicians who wish to interpret and utilize these results properly. Color Doppler has moved beyond simple visual analysis of regurgitation. This technology requires complex calculations from fluid dynamic equations, and a thorough understanding of it benefits and limitations to be used accurately.

For this reason, it is imperative that Doppler technology be a separate entity that physicians can rely on as we advance our ultrasound technology to aid in the correct diagnosis and management of cardiac diseases. As these subspecialty technologies evolve, physicians and technicians alike, must continue to learn new skills, and elevate their level of training to match these advances. The fact that national CME courses exist in Echocardiography specifically designed to teach practicing cardiologists out of fellowship this technology speaks to the importance of this rapidly evolving field. The fact that ultrasound technicians also require specialized training to perform these examinations further confirms that color flow Doppler represents a distinct and valuable diagnostic entity.

Based on the aforementioned facts, I believe it is critical that color Doppler not be bundled with 2D echo reimbursement. It is a technology that requires additional training and expertise to perform and interpret and since it is not used in every study, and will not be part of the standard exam, it should continue to be reimbursed as a separate additional procedure that enhances the diagnostic utility of the basic echocardiographic exam.

Sincerely,
Lawrence D. Jacobs, MD

Submitter : Mr. Michael Bilger **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

Submitter : **Mrs. Lori Bruntjen-Carter** **Date: 08/16/2007**

Organization : **Memorial Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

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America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Lori Bruntjen-Carter, CRNA, MSN
889 N. Koke Mill Rd
Springfield, IL 62711

Submitter : **Mrs. Barbara McDermott** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

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Submitter : **Dr. Lynn Lebeck** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Ms. Leslie Norwalk, JD
Acting Administrator
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Department of Health and Human Services
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Sincerely,

Lynn L. LEbeck, CRNA, PhD

Submitter : **Dr. Arthur Bert** **Date: 08/16/2007**

Organization : **Woonsocket Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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 cxpress my strongest support for the proposal to increase anesthesia payments under thc 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. As a rural anesthesia provider I have labored under inadequate Medicare reimbursement for anesthesia services for the past 17 years (since the RBRVS system was implemented).

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 of my overhead (malpractice, billing service, etc), and is creating an unsustainable situation for solo practicioners like myself. Given the choice *(and I get them) to care for a non-Medicare patient or a (likely) more cpmolicated Medicare patient, the current reimbursement system almost forces me to not care for Medicare patients. I don't want to walk away from sick elderly patients and so far have refused to do so. Please help me continue to care for these patients without bankrupting myself.

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 : **Mr. David Tarabocchia** **Date: 08/16/2007**

Organization : **Permian Anesthesia Associates Inc.**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

David B. Tarabocchia CRNA

5805 Sundance Place

Midland, TX 79707

Submitter : **Dr. Teresa Abernathy** **Date: 08/16/2007**

Organization : **KMKG Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

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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 : Mr. Marvin Howard CRNA **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

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RE: CMS 1385 P (BACKGROUND, IMPACT)

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Submitter : **Date: 08/16/2007**

Organization :

Category : **Occupational Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am in support of the revisions that would remove physical therapy as an in-office ancillary services exception. The in-office ancillary services exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services in my area. Since a physician referral is required by Medicare for physical therapy, these physicians now refer the patient to their own practice, thus eliminating patient choice. Often times the physician office is less convenient for the patient to attend therapy 2-3 times per week. In addition, the patient also may not receive the specialized therapy services they require had they had access to other therapy providers in the community. Thank you for your consideration.

CMS-1385-P-6121-Attach-1.DOC

#6121

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Submitter : **Mrs. Sherly Jacob** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

_____Sherly Jacob_____
Name & Credential
__2975 Mapleleaf ct_____
Address
____Sterling hts,MI 48314_____
City, State ZIP

Submitter : **Kirk Poenicke** **Date: 08/16/2007**

Organization : **Kirk Poenicke**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

Kirk Poenieke, CRNA
2743 Spielman Hts Dr
Adrian Michigan, 49221

Submitter : **Mr. John Young, CRNA** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018
RE: CMS-1385-P (BACKGROUND, IMPACT)
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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Mr. Derek Conner** **Date: 08/16/2007**

Organization : **Lake Charles Anesthesiology**

Category : **Other Health Care Professional**

Issue Areas/Comments

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Scrvices
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Submitter : Mr. Walter Jones, Jr **Date:** 08/16/2007

Organization : Mr. Walter Jones, Jr

Category : Other Health Care Professional

Issue Areas/Comments

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Submitter : **Mr. Greg Stocks** **Date: 08/16/2007**

Organization : **Law Med Consulting LLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

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Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Sincerely,

Gregory Stocks CRNA EJD
640-D North Calvert St.
Baltimore, MD 21202

Submitter : **Mr. Mike MacKinnon** **Date: 08/16/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

RE: CMS 1385 P (BACKGROUND, IMPACT) ANESTHESIA SERVICES

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Submitter : **Mrs. Robin Armer** **Date: 08/16/2007**

Organization : **Mrs. Robin Armer**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 20, 2007
Ms. Leslie Norwalk, JD
Aeting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,

Robin LuAnn Armer, CRNA, M.S.
9408 Sundance Drive
Pearland, TX 77584

Submitter : Mr. Paul Backus **Date:** 08/16/2007

Organization : Mr. Paul Backus

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

I encourage our legislators to approve the proposed reimbursement increases.Previous cuts have put a strain on providers. This increase would help offset the negative impact of previous cuts and increases in the cost of delivering services. Thank You.

Submitter : **Mrs. geralyn evon-gabourie** **Date: 08/16/2007**

Organization : **american association of nurse anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Submitter : **Mrs. Janet Ergle** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,
Janet G. Ergle, CRNA
327 24th St SW
Winter Haven, Fl 33880

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician self referral for profit in physical therapy is rampant in this community. These physicians demand or at the least strongly urge their patients with need for physical therapy to attend their own clinics under the guise that the therapy is superior which is rarely the case. Former patients of these practices relate experiences of being processed like cattle, assembly line therapy and receiving therapy from less than qualified individuals due to the sheer volume of therapy referrals generated by the orthopedic profession. These clinics are not only petri dishes for fraud and abuse but create an atomosphere of substandard care that not only injures the profession of physical therapy but the entire concept of quality care as a whole. Because physical therapy is included in the in-office exception process these clinics continue to flourish and in fact grow. I find this outrageous both as a professional physical therapist and even moreso as a taxpayer. Please consider amending this legislation such that physicians will not be able to refer to themselves for physical therapy services. Their motive for continuing this practice is purely predicated on self profit and the quality of rehabilitative medicine could be clearly enhanced by eliminating this practice. Thank you.

Submitter : Mrs. Esra Neale **Date:** 08/16/2007

Organization : Mrs. Esra Neale

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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Sincerely,

Esra Neale, SRNA

111 Barclay Lane
Cherry Hill, NJ 08034

Submitter : **Mr. Blaine Armer** **Date: 08/16/2007**

Organization : **Mr. Blaine Armer**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

Blaine Armer CRNA, M.S.
9408 Sundance Drive
Pearland, TX 77584

Submitter : **Mrs. Theresa Lemieur** **Date: 08/16/2007**

Organization : **Mrs. Theresa Lemieur**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

Theresa Lemieur SRNA

801 S. Olive Ave #210
West Palm Beach, FL 33401

Submitter : **Mrs. Kelly Rodgers** **Date: 08/16/2007**

Organization : **Mrs. Kelly Rodgers**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

Kelly Rodgers, CRNA
20566 Rhoda St
Woodland Hills, CA 91367

Submitter : Dr. Burke Gurney **Date:** 08/16/2007

Organization : University of New Mexico

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

It is unfortunate that the Stark physician self-referral law has such a gaping loophole (the in-office ancillary services exception). It renders the intent of the law, to stop referrel for profit, functionally inept. the irony is that orthopaedic surgeons, who are already making in excess of 1/2 a million dollars a year, are the beneficiaries of this loophole, and the consumers are the victims. I have been a physical therapist, a physical therapist educator, and a consumer of physical therapy for 25 years, and have seen the full effect (or lack there of) of the Stark law. There is irrefutable evidence that physician owned PT clinics charge more per diagnosis than non-physician owned clinics. Unfortunately, it is obvious that the law isn't working and that referrel for profit is alive and well in physician owned clinics.

Submitter : Suzanne Armstrong **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

I'm asking for support of CRNA fees without cutting into their entitlement fees. Thank you

Submitter : **Mr. Arnold Courtney** **Date: 08/16/2007**

Organization : **American Association of Nurse Anesthetist**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

Arnold Courtney, Jr, RN, SRNA, BSN (student nurse anesthetist)
14607 North Bel Air Drive
Cumberland, MD 21502

Submitter : **Mr. Marvin Jones** **Date: 08/16/2007**

Organization : **Ozarks Anesthesia Associates, LLC**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

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August 16, 2007
Ms. Leslie Norwalk, JD
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Sincerely,

Marvin L. Jones, MSN, CRNA

Managing Partner

Pain Treatment Associates, LLC &

Ozarks Anesthesia Associates, LLC

PO Box 1057

West Plains, MO 65775

417-256-2225 Fax: 417-256-2373

Submitter : **Ms. Rebecca Steinhardt** **Date: 08/16/2007**

Organization : **Ms. Rebecca Steinhardt**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:

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Rebecca Steinhardt SRNA
122 Burr Rd. Apt # 260
San Antonio, TX 78209

Submitter : Jon Wilton **Date:** 08/16/2007

Organization : AANA

Category : Other Practitioner

Issue Areas/Comments

GENERAL

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First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.

Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.

Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Jon Wilton RN CCRN SRNA
15212 Monthaven Park
Hendersonville TN 37075

Submitter : Mr. Michael Mellon **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Ms. Norwalk:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
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Sincerely,
__Michael J. Mellon, CRNA,MS_____
Name & Credential
__6 Durham Drive_____
Address
____Pottsville, PA. 17901_____
City, State ZIP

Submitter : **Mr. Micah Playman** **Date: 08/16/2007**

Organization : **Mr. Micah Playman**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

See attached. Thank you.

CMS-1385-P-6145-Attach-1.DOC

#6195

August 16, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Sincerely,

Micah Playman, MSN, ACNP, SRNA
1118 Greenmeadow Dr
Waukesha, WI 53188

Submitter : **Mrs. Tamara Kaye** **Date: 08/16/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

_____
Name & Credential
_Tamara E. Kolodzik Kaye_____
Address
6511 Hatcher Lane _____
City, State ZIP
Westerville, Ohio 43081

Submitter : **Ms. Dale Jowers** **Date: 08/16/2007**

Organization : **AANA**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Dale S. Jowers_CRNA

4698 Northside Drive

Atlanta, GA 30327

Submitter : Mr. Thomas Carpenter **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

I am writing this in support of the Centers for Medicare and Medicaid Services proposal to boost the value of anesthesia. This proposal would ensure that Certified Registered Nurse Anesthetists <CRNAs> Can continue to provide the necessary anesthesia services so needed by the Medicare/Medicaid community

Submitter : **Laura Brumbaugh** **Date: 08/16/2007**

Organization : **JLR Anesthesia**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Submitter : Mr. Michael Churchin **Date:** 08/16/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Submitter : **Mr. Andrew Shaw** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

__Andrew Shaw_____
Name & Credential
__716 S. Sanders Rd._____
Address
___Hoover Al, 35226_____
City, State ZIP

Submitter : **Karen Wu** **Date: 08/16/2007**

Organization : **AANA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

_Karen Wu, SRNA, RN, BSN, CRT___
Name & Credential
_74-34 43rd Ave___
Address
_Elmhurst, New York 11373
City, State ZIP

Submitter : **Dr. Richard Tompson** **Date: 08/16/2007**

Organization : **Ozarks Anesthesia Associates, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Society of Anesthesiologists (ASA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs), as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Sincerely,

Dr. Richard G. Tompson, MD
Medical Director and Associate Partner
Ozarks Anesthesia Associates, LLC and Pain Treatment Associates, LLC
ph. 417-256-2225

Submitter : **Kenneth Will** **Date: 08/16/2007**

Organization : **Kenneth Will**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%.

Submitter : **Carolyn Poche'** **Date: 08/16/2007**

Organization : **Carolyn Poche'**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

_Carolyn Poche C.R.N.A._____
Name & Credential
_305 Ridgeway Drive_____
Address
_Metairie, LA 70001_____
City, State ZIP

Submitter : **Ms. Barbara Klube** **Date: 08/16/2007**

Organization : **Barbara Klube, CRNA, PS**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

Certified Registered Nurse Anesthetist

CMS-1385-P-6156-Attach-1.DOC

CMS-1385-P-6156-Attach-2.TXT

#6156

August 20, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : Mr. Robert Wilimzig, CRNA **Date:** 08/16/2007

Organization : Mr. Robert Wilimzig, CRNA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

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Sincerely,

Robert L. Wilimzig, CRNA
17 Rosaires Way
Little Rock, AR 72223

Submitter : **Mr. Jim Henderson** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Jim Henderson, CRNA
106 Ember Way
LaGrange, GA 30240
706-882-5658
sandman3@charter.net

Submitter : **Ms. Barbara Berkley** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

see attached

CMS-1385-P-6159-Attach-1.DOC

6159

August 20, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

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Sincerely,

Barbara K. Berkley, RN, BSN, SRNA
100 LeBlanc Court
Cary, NC 27513

Submitter : Mr. Ronnie Handwerger **Date:** 08/16/2007

Organization : Mobile Physical Therapy Services

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a practicing physical therapist that has worked in the environment of a physician's office as well as in a private practice settling, I can certainly see the pitfalls from allowing physicians self referring. It is not fair for the patient to automatically be directed to the physical therapist that is under roof with the physician. That does not guarantee quality treatment and can certainly cause misuse of physical therapy. Patients can be directed to physical therapy for profit reasons vs. need. I think that the patient and Medicare can both be financially abused by the practice of self referral. It does not hamper good treatment to have a patient referred outside of the physicians office. Thank you.

Submitter : Mr. S. Lance Ogle **Date:** 08/16/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

August 20, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Lance Ogle, M.S., CRNA
2900 W. New Hope Rd.
Rogers, AR 72758

Submitter : Ms. Mary O'Sullivan **Date:** 08/16/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Provider

Issue Areas/Comments

Background

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Submitter : **Mr. benjamin Stephens** **Date: 08/16/2007**

Organization : **Mr. benjamin Stephens**

Category : **Other Health Care Professional**

Issue Areas/Comments

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August 20, 2007
Ms. Leslie Norwalk, JD
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Benjamin Michael Stephens

220 Old Hwy 5 North
Thomasville,AL 36784

Submitter : Dr. Joseph O'Sullivan **Date:** 08/16/2007

Organization : American Association of Nurse Anesthestists

Category : Other Health Care Professional

Issue Areas/Comments

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Submitter : **Mr. Michael Twilley, BSN, CRNA** **Date: 08/16/2007**

Organization : **Mr. Michael Twilley, BSN, CRNA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 16, 2007
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Acting Administrator
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Sincerely,

Michael H. Twilley, BSN, CRNA
7309 Selma Drive
Fenton, MI 48430-9015

Submitter : Mr. Saeed Yacouby **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
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Sincerely,

Saeed M Yacouby
Chief Nurse Anesthetist Texas Childrens Hospital
2807 Plantation Lake
Missouri City, Texas 77459
281-438-7488

Submitter : Mrs. Nicole Moore **Date:** 08/16/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007

Ms. Leslie Norwalk, JD

Acting Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

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Sincerely,

Nicole M Moore, CRNA, MSN in Nurse Anesthesia
PO Box 268
Milton LA 70558-0268

Submitter : **Ralph Erickson** **Date: 08/16/2007**

Organization : **Ralph Erickson**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
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Sincerely,

Ralph Erickson, CRNA
870 Indian Point Road
Mount Desert, ME 04660

Submitter : Mr. Robert Wagner **Date:** 08/16/2007

Organization : Mr. Robert Wagner

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
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Sincerely,

Robert Wagner, CRNA_____
Name & Credential
530 East 76th Street Apartment 8J_____
Address
New York, New York 10021_____
City, State ZIP

Submitter : Mr. John McIntyre **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

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Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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Sincerely,

John McIntyre SRNA, CCRN

PO BOX 493
Jackson, MO 63755

Submitter : **Mr. Alan Ambrose** **Date: 08/16/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 138-P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Alan W. Ambrose, CRNA
2173 Schaeffer Rd
Abington, PA 19001
(215) 517-5097

Submitter : **Dr. Daniel Conrad** **Date: 08/16/2007**

Organization : **Anesthesiology Associates of Tallahassee**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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.

Daniel P Conrad MD
danco19@yahoo.com
practicing in Tallahassee, Florida since 1980

Submitter : Mrs. Sandra Smith **Date:** 08/16/2007

Organization : Physical Therapy Solutions,LLC

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

With all due respect, I submit the following comments. As a 15 year veteran Physical Therapist, I can honestly say that I have seen our profession negativley effected by thc addition of physician owned practices. These practices havc captured a population of patients that was once served by independent physical therapist and those employed by corporations that did not have a self serving interest. As healthcare has changcd and with more and more of the bottom line dollar being taken from physicians pockets, these individuals have been forced to resort to other avenues for income streams. The service of physical therapy is one such avenue. However,they are often hiring a less than qualified individual such as an athletic trainer or physical therapist assistant to provide services as they can be hired in at a lesser salary. They are also often hiring physical therapist in at a salary that is more competetitve than the salaries that are offered outside of this arena. It is also not uncommon for them to hire new graduates and those who are younger and less experienced. These individuals are enticed by the glory of working side by side with physicians at a higher salary. Keep in mind that these physicians are not working side by side with these therapists. They are too busy seeeing patients and performing surgery. In light of the shortage of qualified therapist,all this has made it difficult for those of us who own our own pracitce, myself included, to fill positions in our practice. It has also become more difficult for those of us outside of this arena to contniue to thrive, as we are essentially unable to compete for these patients any longer. They are being captured by these physician, who own the practice. And truely, quite honestly, the patient does not know the difference. They are not really being given other choices and do not understand that there really is a difference...a big difference! As an individual in private practice, I pride myself in the quality of care that I provide for my patients! I spend 45-70 minutes with each and every patient I see. It is one-on one at ALL time with ALL patients...not just the Medicare patients. The standards set by Medicare are the Gold standards for all patients seen at my clinic. I know for a fact that these offices owned by physicians are seeing multiple patients at the same time and insurance companies including Medicare are being billed for one on one codes.With all this in mind, you can see that this is a thriving environment for fraud and abuse. The bottom line in submitting these comments is to call on CMS to remove physical therapy from the 'in office ancillary services' exception to the federal physician self rcferral laws. Please close this loophole in the Stark physician self referral law and protect physical therapy serviccs as Congress originally intended.

Submitter : **Mr. Mark Luby Howard** **Date: 08/16/2007**

Organization : **Hamot Medical Center School of Anesthesia**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,
Mark A. Luby Howard, SRNA
509 Shenley Dr.
Erie, PA 16505

Submitter : Mr. Joel Briner **Date:** 08/16/2007

Organization : Mr. Joel Briner

Category : Other Health Care Professional

Issue Areas/Comments

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Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been in private practice for 15 years and have seen a huge change in referral patterns as physicians are referring to their own pocket. I used to receive 5-8 referrals/month from an orthopedic group. Since they opened their own practice, I don't see their patients anymore. One individual who goes to my church told me that they wouldn't let her come to see me--that she had to go to their place. Referral for profit situations are getting out of hand and are putting therapists out of business, because the P.T. cannot compete on an unlevel playing field. The P.T. may be a great P.T., but the patient will listen to their doctor when the doctor says, "I want you to go over here to physical therapy." Please help the situation by eliminating referral-for-profit situtations. If it was your mother or father, you would want to know that the Doctor is making a decision based on what is best for the patient, rather than what is best for the Doctor's pocketbook.

Submitter : David Finch **Date:** 08/16/2007

Organization : AANA

Category : Health Care Professional or Association

Issue Areas/Comments

Impact

Impact

I work for a rural hospital and every decrease in payments affect the hospital negatively. I feel that if there are continued decrease in payments that down the road there will be no rural hospitals with only big centers that are many miles away.

Submitter : **Mr. Kevin Pollock** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

____Kevin Pollock, CRNA_____
Name & Credential
____4051 Thomason Rd._____
Address
____Sharpsville, PA 16150_____
City, State ZIP

Submitter : Mr. Robert Jewell **Date:** 08/16/2007

Organization : AANA

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I propose an increase in the payment for anesthesia services by Medicare and Medicaid.

Submitter : Mrs. Janice Cansino **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

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Submitter : **Ms. Joyce Bloom** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,
Joyce M Bloom CRNA
727 Sussex Road
Wynnewood, PA 19096-2445

Submitter : **Mr. Manardie Shimata** **Date: 08/16/2007**

Organization : **Ogden regional medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

RE: CMS 1385 P(BACKGROUND, IMPACT)ANESTHESIA SERVICES

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Sincerely,
Manardie F. Shimata CRNA
1159 E. 5700 So.
South Ogden, Ut 84405

Submitter : **Ms. Jennifer Casper** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,

Jennifer M. Casper, CRNA, MS
2007 Langley Road
Uniontown, PA 15401

Submitter : **Dr. David Sterner** **Date: 08/16/2007**

Organization : **Dr. David Sterner**

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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Submitter : Mr. jason andrews **Date:** 08/16/2007

Organization : Mr. jason andrews

Category : Other Health Care Professional

Issue Areas/Comments

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America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Jason Andrews
253 Hollister St.
Manchester, CT. 06042

Submitter : **Dr. John Miner** **Date: 08/16/2007**

Organization : **Mountain West 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. Our senior citizens, who represent the fastest growing segment of our country's population, deserve unfettered access to expert anesthesiology care that only fair reimbursement of the same can ensure.

John E. Miner, MD

Submitter : Jill Guttman **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I fully support the AANA's stance on this issue.

Submitter : Mr. Jeremy Williams **Date:** 08/16/2007

Organization : Mr. Jeremy Williams

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

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Sincerely,

Jeremy O. Williams, RN, BSN, SRNA
1100 Pulaski St., Apt. #912
Columbia, SC 29201

Submitter : **Mr. Dave Gembel** **Date: 08/16/2007**

Organization : **Mr. Dave Gembel**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,

Dave Gembel, SRNA
114 Presidio Pointe
Cross Lanes, WV 25313

Submitter : Mr. jd welty **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Jd Welty III, CRNA

7000 Stoney Creek ST

Sioux Falls,SD 57106

Submitter : **Mr. Jason Espada** **Date: 08/16/2007**

Organization : **Mr. Jason Espada**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 17, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Jason Espada, CRNA, MSN
707 Georgetown Drive
Concord, NC 28027

Submitter : Dr. Karen Schmidt **Date:** 08/16/2007

Organization : Anesthesia & Analgesia Medical Group Inc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P In our area Medicare reimbursement is $15.96 per unit under a "rural" designation when in fact Santa Rosa, California is not rural. Medi-cal reimbursement is $14.01 per unit for the operating room and $17.06 per unit for obstetrical anesthesia. We have a large Medicare population, (approximately 40%+ at Santa Rosa Memorial Hospital}, therefore any effort to improve anesthesia reimbursement would be greatly appreciated! Sincerely, Karen M. Schmidt, D.O.

Submitter : Ms. Lee Ann Nelson **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Lee Ann Nelson, R.N., SRNA
P.O. Box 598
Pinson, AL 35125

Submitter : Mrs. wendy Welty **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Wendy Welty , CRNA
7000 Stoney Creek ST
Sioux Falls,SD 57106

Submitter : **Dr. Garen Simonyan** **Date: 08/16/2007**

Organization : **United Anesthesia Services, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Aeting Administrator
Centers for Medieare and Medieaid 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:

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.

Garen Simonyan, MD
United Anesthesia Services, P.C.

Submitter : **Date: 08/16/2007**

Organization :

Category : Other Practitioner

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

_Olney Todd, SRNA_____
Name & Credential
__107 Spring Circle_____
Address
_Smyrna, TN 37167_____
City, State ZIP

Submitter : Mr. jd Welty III **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Jd Welty III, CRNA
7000 Stoney Creek ST
Sioux Falls,SD 57106

Submitter : **Mr. Thomas Burkett** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

_Thomas Burkett MS, CRNA_____
Name & Credential
_2502 Eaton Road_____
Address
_Wilmington, Delaware 19810_____
City, State ZIP

Submitter : Mrs. wendy welty **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Wendy Welty , CRNA
7000 Stoney Creek ST
Sioux Falls,SD 57106

Submitter : Ms. Jennifer Gordon-Norby **Date:** 08/16/2007

Organization : Hands-On Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please remove physical therapy from the "In-Office Ancillary Services" exception for physician self-referral laws.

Submitter : Dr. John Jones **Date:** 08/16/2007

Organization : Dr. John Jones

Category : Physician

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

Measure 2 for Diabetes should include complete lipid panel.

CMS-1385-P-6206-Attach-1.PDF

#4206

Medicare's Preventive Care Services

To Manage Cholesterol and Your Heart Health

Are You at Risk For Heart Disease?

Risk factors for heart disease include:

- Age (45 or older for men, 55 or older for women)
- Family history of premature cardiovascular disease
- Diabetes
- High cholesterol
- Smoking
- High blood pressure
- Being overweight
- High fat and high cholesterol diet
- Lack of exercise
- Stress

Cardiovascular Screening

Medicare now offers a free cardiovascular screening blood test that checks your cholesterol and Triglyceride levels. Cardiovascular screenings are important because high total cholesterol, low HDL-C, and high Triglycerides are hard to detect without the test. This screening will tell if you have unhealthy cholesterol or Triglyceride levels and can help your doctor diagnose your cardiovascular problems in the early stages.

The earlier you are treated, the more likely you can avoid life-threatening events such as heart attacks and strokes. You may also be able to make lifestyle changes (like changing your diet and activity level) to lower your cholesterol level and stay healthy. There is no deductible or copay for this new test. Medicare will cover cardiovascular screening blood tests once every five years for all asymptomatic beneficiaries.

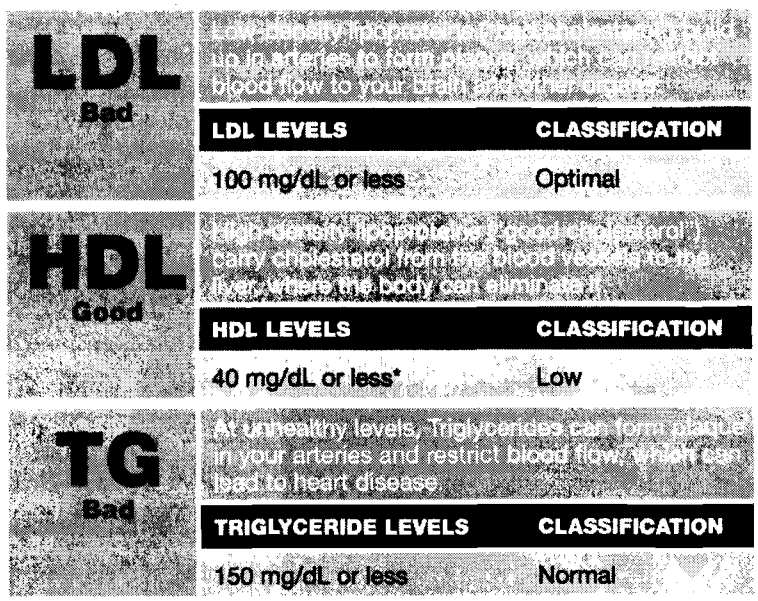
What Is Total Cholesterol?

Cholesterol breaks down into three categories:

- bad cholesterol (LDL)
- good cholesterol (HDL)
- Triglycerides (TG)

Unhealthy levels of any of them can increase your risk for heart disease and stroke, which can be debilitating and life-threatening.

This chart highlights the National Cholesterol Education Program recommendations for lipid levels. A total cholesterol level of less than 200 mg/dL is considered desirable.



*** American Diabetes Association HDL goal levels are:**
Women – 50 mg/dL or less – Low
Men – 40 mg/dL or less – Low

Talk to your doctor about your total cholesterol, LDL, HDL, and TG levels. If any are not at a healthy level, ask your doctor how you can improve them to reduce your risk for heart disease.

If you do not know your total cholesterol, LDL, HDL, and TG levels, ask your doctor about Medicare's free cardiovascular screening.

Maintain a Healthy Weight – Being overweight increases your risk of heart disease, diabetes and high blood pressure. Your doctor can tell you what you should weigh for your height. You can get to your healthy weight and stay there by doing two things: eating right and being physically active.

Stop Smoking – More than 430,000 Americans die each year from smoking. Smoking causes illnesses such as heart and lung disease, stroke and cancer. Exposure to second-hand smoke also increases risk. When you are getting ready to quit:

- Make a plan and set a quit date.
- Tell your doctor that you want to quit smoking and get medicine to help you quit.

Check Your Cholesterol Levels – Have your cholesterol levels checked, including HDL-C and Triglycerides, at least every five years or more frequently if your results are not within normal limits. Medicare provides coverage of cardiovascular screening blood tests for all beneficiaries (without symptoms) every five years. Medicare's cardiovascular screening blood test evaluates total cholesterol, HDL-C and Triglyceride levels.

Medicare Preventive Services and Screenings

Service	Who Is Covered	Frequency	Beneficiary Pays
Initial Preventive Physical Examination (IPPE) *Also known as the "Welcome to Medicare" Physical Exam*	**All Medicare beneficiaries whose first Part B coverage began on or after January 1, 2005**	Once in a lifetime benefit per beneficiary *Must be furnished no later than 6 months after the effective date when the first Medicare Part B coverage begins*	Copayment/coinsurance Deductible
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	**Medicare beneficiaries with certain risk factors for abdominal aortic aneurysm** *Important – Eligible beneficiaries must receive a referral for an AAA ultrasounds screening as a result of an IPPE*	Once in a lifetime benefit per eligible beneficiary, effective January 1, 2007	Copayment/coinsurance No deductible
Cardiovascular Disease Screenings	**All asymptomatic Medicare beneficiaries** *12-hour fast is required prior to testing*	Every 5 years	No copayment/coinsurance No deductible
Diabetes Screening Tests	**Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes** *Beneficiaries previously diagnosed with diabetes are not eligible for this benefit*	• 2 screening tests per year for beneficiaries diagnosed with pre-diabetes • 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested	No copayment/coinsurance No deductible
Diabetes Self-Management Training (DSMT)	**Medicare beneficiaries at risk for complications from diabetes or recently diagnosed with diabetes** *Physician must certify that DSMT is needed*	• Up to 10 hours of initial training within a continuous 12-month period • Sebsequent years: Up to 2 hours of follow-up training each year	Copayment/coinsurance Deductible
Medical Nutrition Therapy (MNT)	**Medicare beneficiaries diagnosed with diabetes or a renal disease**	• 1st year: 3 hours of one-on-one counseling • Subsequent years: 2 hours	Copayment/coinsurance Deductible
Screening Pap Tests	**All female Medicare beneficiaries**	• Annually if high-risk, or if childbearing age with abnormal Pap test within past 3 years • Every 24 months for all other women	Copayment/coinsurance for Pap test collection *(No copayment/coinsurance for Pap lab test)* No deductible
Screening Pelvic Exam	**All female Medicare beneficiaries**	• Annually if high-risk, or if childbearing age with abnormal Pap test within past 3 years • Every 24 months for all other women	Copayment/coinsurance No deductible
Screening Mammography	**All female Medicare beneficiaries age 40 or older**	Annually	Copayment/coinsurance No deductible
	Female Medicare beneficiaries ages 35 - 39	One baseline	

For more information about Medicare's Preventive Services, visit **www.medicare.gov** on the Web or call **1-800-633-4227**. TTY users should call **1-877-486-2048**.

Medicare Preventive Services and Screenings

Service	Who Is Covered	Frequency	Beneficiary Pays
Bone Mass Measurements	Medicare beneficiaries at risk for developing osteoporosis	Every 24 months *More frequently if medically necessary*	Copayment/coinsurance Deductible
Colorectal Cancer Screening	• Medicare beneficiaries age 50 and older • Screening colonoscopy: individuals at high risk; no minimum age requirement • No minimum age for having a barium enema as an alternative to a high-risk screening colonoscopy if the beneficiary is at high risk	• Fecal occult: Annually • Flexible Sigmoidoscopy: Every 4 years or once every 10 years after having a screening colonoscopy • Screening Colonoscopy: Every 24 months at high risk; every 10 years not at high risk • Barium enema: Every 24 months at high risk; every 4 years not at high risk	No copayment/ coinsurance or deductible for Fecal Occult Blood Tests For all other tests copayment/coinsurance apply No deductible
Prostate Cancer Screening	All male Medicare beneficiaries age 50 or older (coverage begins the day after 50th birthday)	Annually	Copayment/coinsurance Deductible
	All male Medicare beneficiaries age 50 or older (coverage begins the day after 50th birthday)	Annually	No copayment/coinsurance No deductible
Glaucoma Screening	Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African Americans age 50 and over, or Hispanic Americans age 65 and over	Annually for beneficiaries in one of the high-risk groups	Copayment/coinsurance Deductible
Influenza (Flu)	All Medicare beneficiaries	Once per flu season in the fall or winter *Medicare may provide additional flu shot if medically necessary*	No copayment/coinsurance No deductible
Pneumococcal	All Medicare beneficiaries	Once in a lifetime *Medicare may provide additional vaccinations based on risk*	No copayment/coinsurance No deductible
Hepatitis B (HBV)	Medicare beneficiaries at medium to high risk	Scheduled dosages required	Copayment/coinsurance Deductible
Smoking and Tobacco-Use Cessation Counseling	Medicare beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use or take certain therapeutic agents whose metabolism or dosage is affected by tobacco use	2 cessation attempts per year; each attempt includes maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period	Copayment/coinsurance Deductible

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Quick Tips to Keep Your Heart Healthy

- Talk to your doctor about cholesterol levels – total cholesterol, LDL-C, HDL-C, and Triglycerides.
- Have all three cholesterol levels checked in partnership with your doctor according to your health history and level of risk.

DATE	LDL-C	HDL-C	TRIGLYCERIDES	TOTAL-C

OTHER INFORMATION RESOURCES

Search these sites, or check your local library, for information about LDL-C, HDL-C, and Triglycerides and how they relate to heart disease.

www.cms.hhs.gov/CardiovasDiseaseScreening/

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) SPONSORED

- Information on heart disease and Medicare cardiovascular disease screening and preventive services

www.americanheart.org/cholesterol

AMERICAN HEART ASSOCIATION SPONSORED

- Information on cholesterol, risk factors, exercise, and healthy recipes

Submitter : **Mr. John Pauzauskie** **Date: 08/16/2007**

Organization : **John M Pauzauskie CRNA PLLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
John Pauzauskie CRNA

Name & Credential
__901 Oakdale Drive
Address
Jasper Texas 75951
City, State ZIP

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Please close the loop hole for referral for profit. In our area many Physicians have opened their own PT clinic. We have seen some patients after they have been seen in Physician PT offices and these patients have complained that they receive minimal instructions and spend several hours in the clinic with minimal improvements. We have also noticed that there Medicare limit has been used in a short period of time restricting future covered care from outpatient facilities of their choosing.
Most people on Medicare are vulnerable and do not want to offend anyone. The Physician s will inform them that they need therapy and give them a referral to their facility without explaining that they can go where they would like. Medicare patients don t understand that they can choose which facility they want to go. Patients have informed us that the Physician s told them that the patient had to go to the Physician facility and expressly discouraged them from going to another outpatient facility, even if it is closer to their home. Thank you for reviewing the loop hole that the physicians have discovered allowing them to profit further off their patients.

Submitter : **Rebecca Smith** **Date: 08/16/2007**

Organization : **Rebecca Smith**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Rebecca M. Smith, MSN, CRNA
4204 Fawn Run
Medina, OH 44256

Submitter : **Dr. Daniel Miller** **Date: 08/16/2007**

Organization : **Dr. Daniel Miller**

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 : Mrs. **Date:** 08/16/2007

Organization : Mrs.

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Name & Credential
LeAnn Lillis
1080 West Main Street Apt 805
Hendersonville, TN 37075

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a 28 year veteran in physical therapy, I have never seen such a devastating effect as I have in the last few years from the physician referral for profit dilemma. Physicians refer to their own rehab service and thereby make a profit from their own referrals.Private clinics and outpatient hospital based clinics have lost patient referrals....except the low payor mix....strategically, the referrals for indigent, Medicare and Medicaid referrals have increased in my clinic...these PT clinics are now the dumping ground for the low payor mix from the physicians.This practice needs to be stopped. I don't understand how anyone could look at this situation objectively and not see the inherent problem it creates. The OIG report has made it clear that this system of "incident to" billing is being abused and the physicians are billing for services not performed by PT's. These services have little or no documentation and do not met the criteria required of physical therapists by Medicare and other regulatory bodies for reimbursement. I have seen PT clinics and private business owners severely effected by this physician owned physical therapy service issue, and the hospital clinic in which I work has seen a tremendous decline in PT referrals with the physicians rehab services capturing the major market. It is interesting and appauling to me that I continue to get the Medicare and Medicaid referrals from the physicians, but not the private payor mix patients. Yet, the physicians say they have opened these privately owned facilities to maintain "quality of care" for their patients. If that is the case, why are they not concerned about the quality of care for Medicaid, Medicare or indigent patients? An audit of the referrals in my clinic would prove that the referrals we receive are low payor mix or indigent patients. This is the case without exception. I challenge any government forum to look at the referrals to hospital based PT clinics such as mine and see for themselves that the only referrals sent to us by the orthopedic physicians are those who are forced to us by contract,indigent, Medicare and Medicaid patients. This is the case without exception for all the orthopedic physicians we serve. This is about making money...not maintaining the quality of care. It is also of interest to note that the "quality of care" issue was raised by many physician groups as the reason they opened their clinics.....funny how in many instances in my city,the physicians hired the therapists who previously worked for the clinic who they say wasn't providing "quality of care" for the patients. I have had one patient this year who preferred to come to my clinic where they had been receiving successful therapy for previous problems, but the physician actually refused to give a PT prescription if the patient did not go to the clinic he suggested. The patient had gone to that clinic and had unsuccessful results, so they desired to return to our clinic, but the physician refused to give a prescription unless the patient returned to the clinic owned by the physician. Of course, this clinic was in his office suite and had been initiated by the physician's group to increase their profit base. The patient went to another physician (family practice MD) to get a referral to our clinic where the patient was more satified with the level of care she had received. The Stark legislation was installed to prevent the obvious abuse that comes with referral for profit situations. The OIG report clearly showed the increase in PT referrals once the physician had a financial interest in the PT clinic. The OIG report also showed the lack of supporting documentation for the proposed PT services billed on the incident to rule. I would like to see this practice of physician referral for profit halted Nationwide. I would also like to see PT billed only by licensed PT's. Physicians are not PT's. Let them bill for physician services...they are physicians. Thank you.

Submitter : Mrs. Erika Watson **Date:** 08/16/2007

Organization : AANA

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

anesthesi needs this increase. I haven't had a raise in 4 years, yet the cost of living has increased. My family may need to apply for medicare/medicaid.

Submitter : **Ms. James Eiring, CRNA** **Date: 08/16/2007**

Organization : **EiringAnesthesia Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,
JAMES EIRING, CRNA

Submitter : James Walker **Date:** 08/16/2007

Organization : James Walker

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,
James R. Walker, CRNA, M.S.
9410 Sundance Drive
Pearland, TX 77584

Submitter : Mrs. Angela Williams **Date:** 08/16/2007

Organization : Mrs. Angela Williams

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Dear Ms. Norwalk:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
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Sincerely,
Angela Williams, SRNA
313 Goldenrod Court
Nashville, TN 37221

Submitter : **Sean Thompson** **Date: 08/16/2007**

Organization : **Sean Thompson**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

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Sincerely,
Sean E Thomposn, BSN SRNA

Submitter : **Dr. Robert Andelman** **Date: 08/16/2007**

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:

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.

Robert J. Andelman M.D.
Staff Anesthesiologist
Portsmouth Regional Hospital
333 Borthwick Ave.
Portsmouth, NH 03801

Submitter : Mr. Jeremiah Fowler **Date:** 08/16/2007

Organization : Mr. Jeremiah Fowler

Category : Nurse

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Jeremiah Christian Fowler
152 Colonial Commons Lane
Columbia, South Carolina 29209

Submitter : Mr. Timothy Holder **Date:** 08/16/2007

Organization : Physiotherapy Associates

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Allowing Physicians to own and refer patients to physical therapy "in office facilities" is both unethical and a disservice to medicare patients. Patients have the right to choose the Physical Therapy facility that offers them the best care available not the facility that increases the Physician profit Margin. Physical Therapy is a Autonomous Profession (not a x-ray machine or MRI) and is not controlled by Physicians. Physicians and Physical Therapist should collaberate professionally to offer patients the highest quality care. Physicians that refer for profit destroy that relationship and become the sole caretaker for the patients care. For the Physical Therapy Profession to continue to grow and develop elimination of referral for profit is absolutely necessary. Physical Therapist need healthy competition to develop new clinical research ideas and improve the care delivered to patients. Referral for profit takes this healthy competition away by monopolizing the market. There is no more important issue facing the physical therapy Profession today and I hope CMS will consider my concerns and those of my colleagues for the good of the Public. Thank You!

Submitter : **Dr. Michael Banks** **Date: 08/16/2007**

Organization : **Dr. Michael Banks**

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.

Submitter : **Ms. kshama Jayasuriya** **Date: 08/16/2007**

Organization : **Henry Ford health Systems**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

Prescription been sent electronically to a pharmacy helps to avoid fruadulent rs's, prevents errors that would be there if hand written (unable to decipher), and increasing wait times especially in the elderly. Electronic prescriptions should be considered the wave of the the future in providing a paperless enviornment. It creates a better working relationship with the physician /Pharmacist and helps the pharmacist foster better communication with the patient.

Submitter : Mr. JASON GOLLIHAR **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Jason M. Gollihar, CRNA

221 Handsome Jack Road
Abilene, Texas 79602

Submitter : **Date: 08/16/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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Sincerely,

John M.Juve ARNP, CRNA
809 Ridge Rd.
Decorah, IA 52101

Submitter : **Mr. Ahmad Kabiri** **Date: 08/16/2007**

Organization : **Mr. Ahmad Kabiri**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Mrs. Pamela Beach** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Pamela Beach, CRNA
14 Gladney Loop
Rayville, LA 71269

Submitter : Mrs. Terri Haney **Date:** 08/16/2007

Organization : American Society of Echocardiography

Category : Other Health Care Professional

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Sir or Madam

I sit at my computer after a rewarding but tiring day of performing Echocardiograms on patients who seek diagnosis of heart disease. I hope you will listen to my plea. I understand the CMS is proposing to bundle the color flow portion of Echocardiography. Using color flow Dopper is vital to distinguish cardiac pathology. Color Flow Doppler requires a unique skill to enable physicians to accurately interpret cardiac pathology. I can provide the necessary information by using color flow Doppler on each patient during testing. Not providing this information for the cardiologists who read my studies would be like leaving for work without my shoes! It would not be a complete study. It takes an acquired skill to deftly perform the color flow portion of the Echocardiogram and a sharp eye for the cardiologist to interpret the information I provide. To minimize the importance of the color flow portion of an echocardiogram may cause sonographers to take this lightly and not perform a complete study. This could be detrimental to health care and the patients for whom that I have the utmost respect.

Submitter : **Mr. Robert Chamblee** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

Steve Chamblee RN, SRNA
4480 Aberton Drive
Southaven, MS 38672

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Submitter : Ms. Lori Clark **Date:** 08/16/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Serviees
Department of Health and Human ServicesP.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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Sincerely,

Lori Clark BSN, MSN, CRNA

3159 Westwoods Place
Orefield, Pennsylvania 18069

Submitter : **Lorraine Jones** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
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Sincerely,

Lorraine H. Jones, CRNA_____
Namc & Credential
411 Woodson Rd_____
Address
_Piedmont, SC 29673_____
City, State ZIP

Submitter : **Mr. Robert Koressel** **Date: 08/16/2007**

Organization : **Mr. Robert Koressel**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
Robert G. Koressel CRNA
4050 Potosi Rod
Pensacola, FL 32504

Submitter : **Dr. Jieun Susana Choi** **Date: 08/16/2007**

Organization : **ASA**

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 : Mr. Jeffrey Brown **Date:** 08/16/2007

Organization : Alabama Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medieare beneficiaries with aeeess to anesthesia services.

This increase in Medieare payment is important for several reasons.

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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Submitter : Mr. Peter Ogren **Date:** 08/16/2007

Organization : American Association of Nurse Anesthetists (AANA)

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

RE: CMS 1385 P (BACKGROUND, IMPACT) ANESTHESIA SERVICES

Attached is my letter to Ms. Leslie Norwalk in support of proposed changes to the anesthesia modifiers.

CMS-1385-P-6238-Attach-1.DOC

#6238

August 18, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

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Sincerely,

Peter W. Ogren, CRNA, MS
Ret. USAF Major
202 Betsy Ln.
Richmond, KY 40475-8524

Submitter : **Mr. Benjamin Randolph** **Date: 08/16/2007**

Organization : **American Association of Nurse Anesthetist**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Dear Ms. Norwalk:

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Sincerely,

Ben Randolph, RN,BSN,SRNA

Submitter : **Mary Giles** **Date: 08/16/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

_Mary Rebecca Giles, CRNA, MSNA
Name & Credential
_1004 Fairway Ct._____
Address
_Independence KY 41051_____

Submitter : Mr. Steve Siebert **Date:** 08/16/2007

Organization : Mr. Steve Siebert

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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Sincerely,

Steve Siebert MS, CRNA
2008 Tadley Street
Columbia MO 65203

Submitter : **Dr. William Daily** **Date: 08/16/2007**

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)

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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.

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Thank you for your consideration of this serious matter.

Sincerely,
William H Daily, M.D.

Submitter : **Mrs. Deborah Kirkendall** **Date: 08/16/2007**

Organization : **Mrs. Deborah Kirkendall**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,
Deborah Kirkendall RN, BSN, SRNA
281 Rocky Branch Rd
Chapmanville WV 25508

Submitter : **Dr. yunping Li** **Date: 08/16/2007**

Organization : **Beth Israel Deaconess Medical Center, boston, MA**

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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Thank you for your consideration of this serious matter.

Submitter : Ms. J Altieri **Date:** 08/16/2007

Organization : Ms. J Altieri

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I think it is ludicrous that CMS is trying to stop reimbursement for an x-ray to demonstrate a subluxation. CMS does recognize the importance of the subluxation and continues to reimburse for treatment of this condition. So why would they stop reimbursing non chiropractic physicians for taking fils for a chiropracor to determine subluxation? By demonstrating subluxation on x-ray you are assured that there is indeed a subluxation that is causing a spinal problem..However, I would want an x-ray of my spine not only to locate a subluxation but also to rule out any fracture or tumor, etc, before having any manipulation. This service should not only continue to be covered by medicare for reimbursement taken by a non-chiropractic physician ordered by a chiropractor; BUT, the CMS should cover x-rays taken by the chiropractor !! If a subluxation is suspected the patient is going to have to pay for this service to continue with the care needed to relieve the pain associated with this condition....Plcae get your head out of the sand on this issue...Chiropractic helps many people and this ruling that would not reimburse a physican for taking an xray just puts more burden on the denior population to try to alleviate their daily pain and suffering...Thanks

Submitter : Dr. Loraine Lovejoy-Evans **Date:** 08/16/2007

Organization : Independence Through Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter

CMS-1385-P-6246-Attach-1.DOC

#6246

INDEPENDENCE THROUGH PHYSICAL THERAPY

Loraine Lovejoy-Evans, MPT, DPT

16 August 2007

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: Physician Self-Referral Issues
Medicare Program
Proposed Revisions to Payment Policies under the Physician Fee Schedule,
and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Weems;

My name is Loraine Lovejoy-Evans, MPT, DTP, and I work as a physical therapist in a rural area Sequim/Carlsborg, Washington, in a private practice as the only clinician in a small office. I have been a physical therapist for 14 years and work diligently to improve my own skills and I teach across the country as an educator providing clinical education and as an adjunct faculty professor in special areas of swelling management strategies.

I am writing about the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. I am concerned about the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

The potential for fraud and abuse exists when physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care.

In my practice I have had 2 patients I had been working on preoperatively who were then told by the orthopedic surgeon that they would need to see the therapist in their office rather than continuing with myself. Both of these patients were pleased with the care I provided and felt that my skills actually exceeded those of the clinicians employed by the physician. I would have completely understood if the therapist employed in the physician's office had skills that exceeded mine, however, this appeared to be a pure profit motivation and inconvenienced the patients who both had to drive an extra 60 minutes round trip for each visit. Needless to say, I was personally appalled at this behavior. I recommend patients see clinicians who live close to their homes rather than drive to my clinic if there is someone with skills that are appropriate. I think this is a good example of how a physician would see this as a money generating issue rather than truly getting the best care for the patient.

I very much appreciate your time and consideration of this issue on my behalf. If I can be of further service to you regarding this issue, please do not hesitate to contact me.

Very Truly Yours,

Loraine Lovejoy-Evans, MPT, DPT
Carlsborg, WA 98324

Submitter : **Ms. Margaret Tierney** **Date: 08/16/2007**

Organization : **Ms. Margaret Tierney**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Submitter : **Dr. Norman Freeman** **Date: 08/16/2007**

Organization : **Dr. Norman Freeman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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 complieated issue.

As an anesthesiologist in Florida medicare is an ever increasing part of of my practice. Medicare reimbursement does not cover the costs of providing vital, expert anesthesia services for medicare seniors 24hrs a day 7 days per week. I fear that if RVU for anesthesia services is not increased I and my colleagues can not continue to provide anesthesia services to our seniors at a financial loss.

Thank you for your attention to this serious matter.

Sincerely,

N George Freeman MD

Submitter : Dr. Joseph Carpenter **Date:** 08/16/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

In fairness to the anesthesia community, please give appropriate consideration to raising the dollar value of the Medicare ASA unit value.
I pay my plumber to come fix my faucet more than I am paid for the same time to care for the aging American population!!!
Thanks for your consideration. JDC

Submitter : Dr. Steve Engen, DC. **Date:** 08/16/2007

Organization : Dr. Steve Engen, DC.

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Sirs; You have to be kidding if you are even thinking about ripping off our country's finest citizens; our senior citizens. When a medicare patient needs x-rays to make a diagnosis; your job is to pay for them according to your fee schedule. To discriminate against any one licensed provider type is scandalous! Stop that discrimination now; ONLY YOU CAN DO IT; SO DO IT!!! SWE

Submitter : **Ms. Stephanie Alcee** **Date: 08/16/2007**

Organization : **Millennium Anesthesia Care**

Category : **Other Health Care Provider**

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
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Thank you for your consideration of this serious matter.
Stephanie Alcee, CRNA
Millennium Anesthesia Care
Tampa, FL

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

This note is a request for CMS to remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws. I know several area physicians who use aides and relatives in their offices to use ultrasound or electrical stimulation on patients multiple days and bill as 'physical therapy' without any exercises, ergonomics or other skilled care for recovery and prevention of re-injury. Physical therapists have a reimbursement cap for their care to Medicare patients. We must tailor our patient care for the best outcomes with a skilled service to each patient. This is the quality of care for which CSM should reimburse, not for modalities only given by a non-physicial therapist without the Master of Science of Clinical Doctorate education of physical therapists. Again, I ask for the progressively more limited Medicare dollars to be spent for physical therapy only given by a licensed physical therapist. Thank you for this consideration.
Topeka PT

Submitter : **Mr. Charles Frisch** **Date: 08/16/2007**

Organization : **Mr. Charles Frisch**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 16, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

_Charles A Frisch, CRNA, BS, MS. FAAPM, CH
1021 Dakota Ave
Alliance, NE 69301-2334

Submitter : **Mr. Jared Allred** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Jared Allred
Student Registered Nurse Anesthetist
jared357@gmail.com

Submitter : **Ms. Valorie Wogsland** **Date: 08/17/2007**

Organization : **Independent**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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This increase

Submitter : Mr. Bruce Herr, Jr. **Date:** 08/17/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

August 17, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

RE: CMS 1385 P (BACKGROUND, IMPACT) ANESTHESIA SERVICES

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Sincerely,
Bruce A. Herr, Jr., CRNA, MS, BSN
4200 Cathedral Ave. NW, Unit #717
Washington, DC 20016-4934

Submitter : **Dr. Alexander Dubelman** **Date: 08/17/2007**

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:

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. Gary Tom **Date:** 08/17/2007

Organization : St. Mary Prescription Pharmacy

Category : Pharmacist

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

We highly rely on faxed prescriptions from physicians offices, nursing facilities, adult day health centers, etc. Faxed prescriptions make up 90% of our prescription and they have been a necessity for our pharmacy. To change this practice would create too much chaos for all of our providers that we work with. When CMS created this, I'm sure they only accounted for your typical outpatient physicians offices (which tends to be the case for most, if not all of the regulations created by CMS).

Submitter : Dr. Cynthia Kenol **Date:** 08/17/2007

Organization : First Colonies Anesthesiolgy Associates

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Elaine Gromofsky** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

__Elaine Gromofsky, CRNA_____
Name & Credential
_410 Webster Street_____
Address
__Petaluma, Ca 94952_____
City, State ZIP

Submitter : **Mrs. Patricia Lancelotta** **Date: 08/17/2007**

Organization : **Mrs. Patricia Lancelotta**

Category : **Nurse**

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.
Pat Lancelotta

Submitter : **Dr. Bruce Kimble** **Date: 08/17/2007**

Organization : **CVS Pharmacy**

Category : **Pharmacist**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

Please reconsider this regulation, it would seriously affect our business flow.

Thanks for your time,
Bruce D Kimble, PharmD
3957 Cape Cole Blvd
Punta Gorda, FL 33955
Tel 941-639-8510
Cell 773-350-1648

Submitter : **Dr. Jefffrey Nachman** **Date: 08/17/2007**

Organization : **Dr. Jefffrey Nachman**

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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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. Stephen Thompson **Date:** 08/17/2007

Organization : Anesthesiologists of Greater Orlando

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the AMA RUC proposal to boost the anesthesia conversion factor. For my 21 years of practice, it has been obvious that CMS has grossly undervalued anesthesia services. In many places with large Medicare populations, anesthesia practices struggle to survive. The proposed increase will go a long way in helping to continue to be able to provide quality service to the elderly and disabled. Thank you for your consideration, Stephen W. Thompson MD

Submitter : **Dr. Chris Carraway** **Date: 08/17/2007**

Organization : **Dr. Chris Carraway**

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

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 non-treating provider 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 for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors 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,

Chris Carraway, DC DIBCN FIACN

Submitter : **Dr. Scott Benzuly** **Date: 08/17/2007**

Organization : **Brown University/Rhode Island Hospital**

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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Thank you for your consideration of this serious matter.

Scott E. Benzuly, MD

Submitter : **Ms. Jessica Plaice** **Date: 08/17/2007**

Organization : **Ms. Jessica Plaice**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Submitter : **Mr. Marlen Jost** **Date: 08/17/2007**

Organization : **Mr. Marlen Jost**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007.....
Ms. Leslie Norwalk, JD.....
Acting Administrator.....
Centers for Medicare & Medicaid Services.....
Department of Health and Human Services.....
P.O. Box 8018.....
RE: CMS-1385-P (BACKGROUND, IMPACT).....
Baltimore, MD 21244-8018.....
ANESTHESIA SERVICES.....

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.....
Sincerely,
Marlen B. Jost, CRNA, MSN
7853 Wildberry Ct
Portage, MI 49024

Submitter : Dr. J. Scott Diquattro **Date:** 08/17/2007

Organization : Diquattro Chiropractic

Category : Health Care Professional or Association

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

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Sincerely,

J. Scott Diquattro, D.C.
Diquattro Chiropractic
400 S. Farrell Drive, Suite B-105
Palm Springs, CA 92262
(760) 416-9199

Submitter : **Ms. Arlene Waldo** **Date: 08/17/2007**

Organization : **AANA**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Submitter : Dr. Stephen Taylor **Date:** 08/17/2007

Organization : BPIOD

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Please do not consider this proprosal. This is a horrible blow to chiropractic patients. Please do not implement this.... CMS-1385-P - Revisions to Payment Policies Under the Physician Fee Schedule. Dr. Taylor

Submitter : Dr. James Lefebvre **Date:** 08/17/2007

Organization : Lefebvre Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposed changes for radiology in the revision would negativly impact the care for the patient as well as your budget. If a Chiropractic provider has to refer to a primary for x-rays to be taken by a radiologist it will cost medicare futher expense for a second consultation. It will also cause delay in onset of patient treatment. This delay then could have a negative impact on the patients condition. As a result this could result in requiring increased services. This "cost saving revision" then in actuality would be costing medicare not saving it money.
I urge the administration to at minimum to leave the current regulations in place and possible consider reimbursment for x-rays in the chiropractor's office, taken by the chiropractor, which would lead to a cost savings for your plan. Not only would the patient have more timly care, reimbursment for x-rays in a chiropractor's office are paid normally at a lower rate than a radiology facility.

Submitter : **Mr. JOhn Aker** **Date: 08/17/2007**

Organization : **Mr. JOhn Aker**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

RE: CMS 1385 P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

" First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
" Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
" Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

John Aker, CRNA, MS
2607 Flagstone Ct
Coralville, Iowa 52241

Submitter : **Dr. John McGinnis** **Date: 08/17/2007**

Organization : **Dr. John McGinnis**

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 non-treating provider 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 for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors 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,

John R McGinnis DC

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a Physical Therapist having worked in rural settings for the past ten years, the Stark Law exited to keep me and my physician-friends from combining our resources for financial gain -- it kept us honest. With the advent of 'in-office ancillary services', I have been approached by several area physicians with long-standing questionable reputations to provide Physical Therapy services under their supervision. Their offers of compensation were very generous which caused me to take interest and speak with them in detail concerning their plans. On every occasion, I found their plans to be directed more toward personal gain than the provision of patient care. Several went so far as to suggest a planned course of action that would allow me to treat patients in the absence of their physical presense which is a clear violation of the exception. Upon expressing my concern, an alternative arrangement was suggested whereby I practice independently and allow the physician billing service to handle the billing and withhold a generous percentage as reimbursement. To date, I have refused all offers and have gone so far as to decline even discussing related inquiries from other physicians.

In my experience, 'in-office ancillary services' exist only to provide opportunities for financial gain to physicians with limited, if any, improvement in patient care. In addition, I have come to realize that this exception exists as a gateway for unscrupulous physicians to further camouflage improper payment policies.

Currently, I provide Physical Therapy services and exist as an expert in the treatment of movement and functional impairments. Physicians and patients who utilize this service realize this as well as their own limitations to administer these services. My compensation is based on the effectiveness of these services to improve a patient's quality-of-life, and I oversee proper reimbursement for these services. I can find no exception were any physician who has not been trained as a Physical Therapist would improve the quality or efficiency in the delivery of these services. Thus, this provision fails to improve patient care and cannot save money.

Thank you for considering my comments. I hold-out hope that the best decision for all is reached.

Submitter : Mrs. Lisa Meyers **Date:** 08/17/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

Submitter : Hugh, Hart **Date:** 08/17/2007

Organization : AANA

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms Norwalk: I support the CMS proposal increasing the anesthesia CF (72FR 38122, 7/12/2007). This will create some measure of equity and support for hospitals providing service for a higher than averge CMS client base of which my facility measures some 50%. Undervalued, yet necessary, anesthesia services compounded by a manpower shortage of both CRNA's and anesthesiologists challenge the managers of all aspects of healthcare to invest equitable funding to ensure delivery of that care. I heartfully endorse the efforts of CMS boosting the reimbursements for Medicare Part B providers delivering anesthesia services.
Sincerely,
Hugh Hart, CRNA
105 Arch St
Ishpeming, MI 49849

Submitter : **Mr. Thomas Duggan** **Date: 08/17/2007**

Organization : **Fairfield Memorial**

Category : **Critical Access Hospital**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Thomas J Duggan CRNA
Chief CRNA
Fairfield Memorial Hospital
Winnsboro SC

Submitter : **Laurence Kam** **Date: 08/17/2007**

Organization : **Metrowest Anesthesia Care**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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 : **Mr. Jonathan Kopchick** **Date: 08/17/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,

Jonathan H. Kopchick, SRNA
26 Hemenway St., Apt 6
Boston, MA 02115

Submitter : **Mrs. Candida Richardson** **Date: 08/17/2007**

Organization : **American Assn. of Nurse anesthestists**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Medicare Proposes Significant Anesthesia Payment Increase:
Agency Needs to Hear from CRNAs

After years of requests from AANA and anesthesiologists that Medicare should boost anesthesia payment, the Centers for Medicare & Medicaid Services (CMS) has taken heed and proposed the most significant increase in anesthesia payment in many years.

The Medicare agency issued July 2 and published in the Federal Register July 12 (72 FR 38122, 7/12/2007) a proposed rule providing a 2008 physician fee schedule that would increase the Medicare anesthesia conversion factor (CF) for CRNAs and anesthesiologists by 15 percent, and possibly up to 25 percent if Congress reverses another scheduled Medicare payment cut. In several years comments to the Centers for Medicare & Medicaid Services (CMS), on Capitol Hill as recently as Mid-Year Assembly and thereafter, and as recently as a June meeting with AANA President Terry Wicks, CRNA, MHS, at CMS, the AANA has requested that CMS more appropriately value anesthesia services to more accurately reflect the value of anesthesia work, and to be closer to market payment rates. Among other factors, Medicare pays for most physician services at about 80 percent of market rates, but about 40 percent of market rates for anesthesia services. The proposed rule is subject to public comment with an August 31, 2007, deadline, and to action in Congress.

Medicare pays an anesthesia fee according to the formula FEE = (Base units + Time units) x (Anesthesia CF). Because anesthesia work accounts for three-fourths of the value of the anesthesia CF, this action alone would increase the anesthesia CF by 25 percent, from a national mean $16.23 in 2007, to about $20.29 in 2008. Under such a circumstance, Medicare presumes its national allowed charges will rise 22 percent for CRNAs, and 14 percent for anesthesiologists. Medicare is not paying anesthesia professionals different fees; the difference lies in that CRNAs bill nearly 90 percent of their work under the anesthesia fee schedule which is being given a boost, while anesthesiologists bill nearly a third of their work to the regular physician fee schedule which is remaining constant. However, because Medicare presumes the 10 percent sustainable growth rate formula cuts for 2008 will take effect, the increase in the anesthesia CF under the proposed rule is 15 percent, to a CF of about $18.66.

Estimated Changes in National Anesthesia CF

Anesthesia CFs
VV Action by Congress
2006 Anesthesia CF 2007 Anesthesia CF 2008 Anesthesia CF Proposed 2008 %Chg over 06 2008 %Chg over 07
Reverses 10% SGR cut $17.76 $16.23 $20.29 +14% +25%
Does Not Reverse 10% SGR cut $18.66 +5% +15%

CMS estimates $1.6 billion in Medicare allowed charges for anesthesiology in 2008, and $605 million in allowed charges for nurse anesthetists in 2008, for a total of $2.205 billion in Medicare payments to anesthesia professionals. Again, not all these providers charges are paid under the anesthesia fee schedule.

The bottom-line impact on CRNAs could look like this. For the average CRNA, providing 900 cases a year, 13 units per case, 1/3 of the cases being Medicare, we estimate that the changes as proposed would increase anesthesia payment by $9,400 between 2007 and 2008, holding case mix, volume and intensity constant. Further, if Congress in addition reverses the pending 10 percent SGR cuts, then the average CRNA in the same scenario would see an increase of $15,800, we estimate. These scenarios consider the payment value of a Medicare patient case performed by a CRNA. They do not account for anesthesiologist medical direction which would claim half of a Medicare anesthesia payment.

Submitter : **Dr. Henry Rosenberg** **Date: 08/17/2007**

Organization : **Dr. Henry Rosenberg**

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.

Henry Rosenberg, MD
Professor of Anesthesiology
Mount Sinai School of Medicine
NY, NY

Submitter : **Brian Donn** **Date: 08/17/2007**

Organization : **Atlantic Coast Anesthesia Associates**

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
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Thank you for your consideration of this serious matter.

Brian Donn M.D.

Submitter : **Dr. Robert Garvin** **Date: 08/17/2007**

Organization : **Anesthesia and Pain Assoc. of N.L.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Sincerely,

Robert Garvin, D.O.

Submitter : **Dr. Jean-Nicolas Poirier** **Date: 08/17/2007**

Organization : **Parker College of Chiropractic**

Category : **Radiologist**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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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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 for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors 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,

Jean-Nicolas Poirier, DC, DACBR
Assistant Professor, Department of Diagnostic Imaging
Residency Director
Parker College of Chiropractic
2500 Walnut Hill Lane
Dallas, Texas, 75229

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a practicing physical theapist for the past seven years, I would like to comment on the physician self-referral issues that involve the in-office ancillary services exception. In my opinion, this exception to the fee schedule rules has been taken beyond it's intended purpose and is being used by physicians self-refer patients to their own physical therapy practices. In my time as a physical theapist, I have worked in a physician owned setting as well as independent outpatient clinics. It has been my experience that the quality of care in the physican owned therapy clinics is inferior to independent clinics due to the fact that the physician run clinics have a guarenteed referral source and very little incentive to achieve the highest level of patient outcomes. Often in physician run clinics, technicians provide the majority of the treatment with little therapist intervention after the evaluation. In contrast, in independently run clinics, each patient referral is valuable and good outcomes in a reasonable timeframe is essential to gain the trust of the physicians that have written the referral. This is how independent clinics maintain and grow their business. When each and every patient is considered important and valuable, the quality of care is significantly increased as is overall patient satisfaction. Unfortunately, when patients are referred to a physician-owned physical therapy, they do not realize that they can take their referral to any physical therapy office. They set-up appointments at the physician's physical therapy regardless of convience or ease of scheduling because they do not realize they have any choice in the matter.

It is because of these issues that I ask you to remove physical therapy services from the in-office ancillary service exception. Thank you for the consideration of my comments.

Submitter : **Date: 08/17/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthestists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor by 15% in 2008 compared with current levels. If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services. The increase in Medicare payment is important for several reasons. First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory commiession and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates. Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers' services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia wrok was not adjusted by this process until this proposed rule. Third, CMS'proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments. Additionally, if CMS' proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation). America's 36,000 CRNA's provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency's acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I recently met with several physical therapist who are working a physician owned practice and asked them why they are looking to leave. The answer were as follows, Because every time I want to discharge my patient the physician doesn't let me and tell me they would benefit from another few weeks, they write prescription for patient who don't need care and I end up having to treat the patient, the physician allows unlicensed aide to provide care.

Another issue, that has come up is that several physician refuse to treat patient for a follow up visit if they don't attend their physical therapy and this remove the patient right to choose the level of care they receive despite the fact that several physican office simply don't invest in the physical therapy component of their practice and the patient would actually benefit from a certain therapist or practice , the physican blackmail the patient into going to their PT practic if they want to remain under the care of the physician.

Submitter : **Mrs. Connie Falati** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 17, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Connie Falati, CRNA
1016 Linwood Ave.
Metairie, La. 70003

Submitter : **Mr. Aaron Ketcher** **Date: 08/17/2007**

Organization : **Mr. Aaron Ketcher**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Submitter : **Date: 08/17/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Sincerely,

Kristopher Logan Key SRNA, RN, BSN
Western Carolina University
Nurse Anesthesia Program

Submitter : **Dr. Raymond Allen** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Sioux Falls, SD, 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 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,

Submitter : Dr. Micheal Gilbert **Date:** 08/17/2007

Organization : Parker College of Chiropractic

Category : Radiologist

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

See attached letter.

CMS-1385-P-6294-Attach-1.DOC

#6294

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 non-treating provider 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 for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors 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,

Micheal L. Gilbert, BS, DC
Resident, Department of Diagnostic Imaging
Parker College of Chiropractic
2500 Walnut Hill Lane
Dallas, Texas, 75229

Submitter : Ms. Cynthia Palage **Date:** 08/17/2007

Organization : AANA

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

As an AANA member for over 20 years, I write to support CMS proposal to boost the value of anesthesia work by 32%. If adopted, CMS' proposal would help to ensure that CRNAs ,as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

The increase in payment is important for the following reasons.

Medicare currently under-reimburses for anesthesia services, putting Medicare recipients at risk for not having access to quality anesthesia services. Sudies from the MedPAC and others have demonstrated that Medicare Part B reimburses for most srevices at approximately 80% , but reimburses for anesthesia services at approximately 40% of private market rates.

Most Part B providers' srevices had been reviewed and adjusted in previous years, effective January 2007. Anesthesia services were not adjusted by this process and would be by this proposed rule.

Last,CMS' proposed change in the relative value of anesthesia work would help correct the value of anesthesia services which have long slipped behind inflationary adjustments.

If CMS' proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels(adjusted for inflation).

Tha availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency's acknowledgement that anesthesia payments have been undervalued and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Cynthia Palage, CRNA

Submitter : **Date: 08/17/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 17, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), and as a current student in an anesthesia program, I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

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America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Holly Dells, SRNA

120 Brookhill Drive

Flemingsburg, KY 41041

Submitter : **Dr. Alyssa Simone** **Date: 08/17/2007**

Organization : **United Anesthesia Services**

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 Alyssa Simone

Submitter : **Christee Beals** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Christee Beals CRNA
3 Timberlane
Sioux City, Iowa 51108

Submitter : **Ms. Tammy Moore** **Date: 08/17/2007**

Organization : **Ms. Tammy Moore**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 17, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P
Baltimore, MD 21244-8018 (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Tammy R. Moore, SRNA (Student Registered Nurse Anesthetist)
728 Ave K #2
Galveston, TX 77550

Submitter : **Dr. Rebecca Atha** **Date: 08/17/2007**

Organization : **University Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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 : Dr. Deborah Stetts **Date:** 08/17/2007

Organization : Elon University

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. I am concerned about the potential for abuse of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception. The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care. Ample evidence exists for overutilization of physical therapy services in this case. No evidence exists that the services provided under these circumtances provide current best practice; quality control is absent. As a physical therapist, I strongly support eliminating physical therapy as a designated health service furnished under the in-office ancillary services exception. South Carolina has taken the lead on this issue and CMS should follow.

Submitter : **Dr. Peter Andreone** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Sioux Falls, SD, 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 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,

Submitter : **Mr. Louis DesPres** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

This increase insures availability of qualified anesthesia providers, who are reimbursed at 40% of customary rates.

Submitter : **Mrs. Susan Barnett** **Date: 08/17/2007**

Organization : **UT College of Nursing/ CRNA track**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Ms. Norwalk:
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Sincerely,

Name & Credential

Address

City, State ZIP

Submitter : Dr. Ann Patterson **Date:** 08/17/2007

Organization : Ann B. Patterson MD PC

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I feel that if you cut fees to Physicians by 40% and our costs increase by 20% many physicians will stop seeing medicare patients. There will be an access to care problem. I have already decreased the number of new medicare patients I see for that reason.

Submitter : **Dr. Randall Clark** **Date: 08/17/2007**

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:

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.

Randall M. Clark, MD
21 Hyde Park Circle
Denver, CO 80209

Submitter : **Date: 08/17/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The major concerns in having physicians referring to themselves are many. Specific issues and concerns are provided below:

1. The obvious concern in over utilization of the service for financial gain.

2. The concern that the physician or the physician group does not give the patient a choice as to where to receive therapy, and simply directs the patient to their own physical therapy service.

3. The concern that physicians "push the limit" as to where the therapy service is being offered. Since the reassignment of benefit laws are being used to actually circumvent the "incident-to" requirements, patients may be sent to therapy "down the road" and have no idea the physician actually owns the therapy practice. Patients have the right to know who owns the service.

4. The economic fact that given the short supply of therapists, and given the fact that the APTA, as well as many academic entities, speak out against having therapists work for physicians, the only way for physicians to recruit therapists is through increasing dramatically their salaries, thus pushing health care costs even higher.

5. The fact that there are now many "management companies" that have been started for the express purpose of managing the therapy services within the physician's office. This leads to the conclusion that the physicians are not interested in employing the therapist for the benefit of the patients, but simply want to enjoy any financial gains from the service.

6. The argument that physicians want to be able to refer to quality therapists that they chose for their office is not a strong argument. The fact is that in most all markets in the United States there are quality private practices. I have been a non-clinician participant in the physical therapy industry for 15 years, and have traveled the entire country. Every community has skilled therapists who can earn the referral from the physician.

7. The economic argument that competition in the marketplace works. If physicians can refer to a service in an environment that is competitive, this situation will foster better care and service for the patient.

I believe that CMS should remove physical therapy as a designated health service permissible under the in-office ancillary exception of the federal physician self-referral laws. In doing so, competition will be fostered, potential for financial abuse limited, thus lowering health care costs overall. I plead that CMS must do the right thing!

Submitter : Mrs. Jo Rittermeyer **Date:** 08/17/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

- First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Submitter : **Miss. Jessica Ginn** **Date: 08/17/2007**

Organization : **Miss. Jessica Ginn**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Ms. Norwalk:
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Sincerely,
Jessica Ginn, SRNA
Name & Credential
3220 Clarion Lane
Address
Memphis, TN 38119
City, State ZIP

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist I urge the CMS to remove physical therapy as a designated health service permissable for physicians to utilize on a self-referral basis. It creates increased opportunity for improper utilization and fraud. Furthermore, I work in a clinic which is affected by physician owned physical therapy clinics. Patients are lost to our service when referred to physician that practices such.

Submitter : **Dr. Alfred Hill** **Date: 08/17/2007**

Organization : **Dr. Alfred Hill**

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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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 : Lori Hill **Date:** 08/17/2007

Organization : Lori Hill

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

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Cindy Ryan** **Date: 08/17/2007**

Organization : **Ms. Cindy Ryan**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,,

Cindy Ryan, CRNA, MA

Submitter : Mr. Joe Shahan **Date:** 08/17/2007

Organization : Mr. Joe Shahan

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am opposed to the provision that allows physicians to refer patients to their established clinics for the purpose of referral for profit. this presents an ethical situation where profit and patient interest is in conflict. I hear of abuses from patients that they are steered to the physicians clinics even when they would prefer another therapist, but they are afraid to confront their MD because he might not accept them as patients and the number of MD that accept Medicare is diminishing. therefore they are a captured population that some MD's control to provide them with additional income by funnelling them thru their owned clinics. By prohibiting this type of arrangement it would promote better healthcare thru competition of independent therapists to provide superior services in a cost effective manner. Otherwise the recepient is often forced to comply to the demands of the MD to go to their clinic or risk being dropped by their MD.

Submitter : **Neil Hill** **Date: 08/17/2007**

Organization : **Neil Hill**

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.

Submitter : **Patrick Hill** **Date: 08/17/2007**

Organization : **Patrick Hill**

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.

Submitter : Mr. James Croyts **Date:** 08/17/2007

Organization : Physiotherapy Associates

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My name is James Croyts. I am a licensed Physical Therapist (15 years) in the state of Ohio and I am contacting you today regarding the current review of physician owned ancillary services by the CMS. As I am sure you are aware, the current in-office ancillary services exception to the physician self-referral law allows physicians the opportunity to own and refer to a physical therapy practice that produces financial gain for the physician. This exception, despite the intent to create enhanced patient convenience and accessibility to physical therapy services, has promoted a referral for profit scenario that negatively outweighs the positives it was designed to accomplish. The negatives of physician owned physical therapy practices are easily identifiable when examined. The inherent nature of these practices provides the physician with enhanced motivation (financial gain) to refer the patient for physical therapy services and to recommend longer duration care. As a result, the intended patient convenience is negated by additional visits, expense and in many instances compromised care. The care is compromised as a result of the fact that these practices are most often characterized by exceptionally busy schedules and the utilization of unlicensed staff to facilitate patient care. This strategy reduces the skilled intervention time of the licensed staff and limits effective patient education which is a critical element to the success of any well designed physical therapy intervention.
Regretfully, I speak of these practices from personal experience. I worked in a physician owned physical therapy practice for approximately one year earlier in my career. I entered that employment experience with the illusions that I would be a better clinician and care provider given the close proximity and interaction with the surgeon who performed the surgical intervention. Unfortunately, I found that not only was I not better equipped (communication was not effective nor viewed as necessary) to provide exceptional care, but conversely was asked to consider adding treatment modalities not integral to improved outcomes for the sole purpose of additional reimbursement. Fortunately, I did compromise my ethics by complying with those requests and left the practice shortly thereafter. I am not here to imply that all POPT practices operate in this manner, but conversation with many therapists working in that environment has yielded commentary that suggests these issues are not uncommon. For all these reasons, I implore you and your colleagues to closely examine these practices and the intent of the exception currently in place that allows their existence. I do not believe the majority of these practices meet the criteria of expected care delivery and often abuse the privelage and obligations of the profession they represent. Thus, it is my position that physician owned physical therapy practices should not be permissible under the designated health services 'in-office ancillary service' exception. Thank you for your consideration of this issue.

Sincerely,

James Croyts, PT

Submitter : **Ms. MICHELLE CANNEY** **Date: 08/17/2007**

Organization : **Ms. MICHELLE CANNEY**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Ms. Leslie Norwalk, JD August 17, 2007
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Sincerely,

Name & Credential
__Michelle Canney_, CRNA_____
Address
__8132 Northern Rd._____
City, State ZIP
Minocqua, WI 54548

Submitter : Miss. Rebecca Coburn **Date:** 08/17/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Please see attached document.
Thank you.

CMS-1385-P-6319-Attach-1.DOC

#6319

August 20, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Rebecca C. Coburn, CRNA
Name & Credential
519 Main Street Apt. 2
Address
Lewiston, ME 04240
City, State ZIP

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Our area is directly impacted by a large physician owned facility that has PT/OT services. They as specialists have the ability to evaluate a patient that may currently be recieving services at another facility and discontinue those services to re-start them in their office. This creates additional evaluation charges to the payor that were not necessary and disrupts continuity of care. The 'in-office ancillary services' exception is broad allowing potential abusive referral arrangements. The fact that a physicain referral is required to receive services creates a 'captive client' situation. This has the potential for overutilization. I support the elimination of physical and occupational therapy as a designated health service under the in-office ancillary services exception. CMS would reduce potential for abuse and overutilization.

Submitter : **Mrs. Jamie Hawk** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 17, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,

Jamie Hawk, CRNA

4504 Lafayette Dr
Bismarck, ND 58503

Submitter : Mr. Michael Wentzel **Date:** 08/17/2007

Organization : American Association of Nurse Anesthetists (AANA)

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Ms. Leslie Norwalk, JD

As a member of the American Association of Nurc Anesthetist (AANA), I write to support the Centers for Medicate & Mediciad Services (CMS) proposal to boos the valuc of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

If CMS' proposed change is not enacted and if Congress fails to reverse the 10% substainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and mor ethan a thrid below 1992 payment levels (adjusted for inflation).

America's 36,000 CRNAs proved some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency's acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Michael R. Wentzel, SRNA
70 South 4th Street #411
Memphis, TN 38103

Submitter : Dr. Nadia K **Date:** 08/17/2007

Organization : Dr. Nadia K

Category : Pharmacist

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

As a pharmacist I feel that computer-generated facsimiles are extremely beneficial to the patient, prescribing physician and the pharmacist. It is hassle free and easy to use. Eliminating this option will immensely effect some physician offices who have gone paperless over the last few years. It saves time, money and is convenient to everyone involved in getting a prescription. In our pharmacy, we get computer-generated facsimiles regularly from atleast 3-7 physicians offices. I believe it reduces the workload on physicians and pharmacists and is really helpful in urgent-care situations for patients. Overall, I do not think it is a good idea to eliminate the exemption for computer-generated facsimiles.

Submitter : Dr. J. Michael Bacharach **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Sioux Falls, SD, 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 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,

Submitter : **Ms. Christine Oberndorfer** **Date: 08/17/2007**

Organization : **Ms. Christine Oberndorfer**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

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Sincerely,

Christine Oberndorfer, CRNA

25198 Parkview Drive
Pueblo, CO 81006

Submitter : Dr. Paul Carpenter **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Submitter : Mr. Nick Pesce **Date:** 08/17/2007

Organization : Momentum Physical Rehabilitation

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for accepting our comments. I have been practicing physical therapy (PT) for over 20 years, and have been in private practice for 7. We treat a wide variety of patients of all ages, including orthopedic and neurological conditions.

I am writing to voice my opinion regarding physician-owned PT services, or 'referral for profit.' Healthcare is expensive but necessary, and discouraging arrangements that create incentives for overutlization should be examined. Physicians who have a financial interest in an entity to which they refer have an inherent financial incentive to overutlize those services. Just as if a physician owned a pharmacy, they would have an incentive to prescribe more or higher priced meds, so to do physicians who own PT services have an incentive to order more services. Studies support this contention. The 'in-office ancillary services' exception has created a loophole that has resulted in a major expansion of physician-owned PT services in our area.

The arguments in favor of referral for profit in my experience are specious. Communication between physician and PT are not significantly enhanced, nor do they improve the patient's care. It is not usually more convenient for the patient to return to the physician's office to receive PT - and in our case almost always less convenient. And the level of care received at a physician-owned clinic is not of a higher caliber - our patients that have experienced both settings often tell us the contrary, and outcome studies should support this. Physical therapists do not need nor benefit from direct physician supervision to provide physical therapy.

Although legally the patient has the right to choose their PT provider, they are reluctant to question their physician's recommendation. We frequently hear from patients that their physician insisted they go to the physician's clinic, even when they requested to come to our facility. A surprising number of times, we have referred a patient (who is under our care) to a physician, only to have the physician insist the patient go to their clinic, over the patient's protests. I must say we have excellent, skilled physicians in our area, but the financial incentives encourage them to steer patients to their own clinic, regardless of other factors such as patient preference and convenience. I would assume that their management encourages this practice.

I support removing PT service from the permitted services under the in-office ancillary exception.

Thank you for your consideration.

Sincerely,

Nick Pesce, PT

Submitter : **Dr. Mark Fausch** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

Issue Areas/Comments

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Sincerely yours,

Submitter : Dr. C. Thomas Gaeckle **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

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Submitter : **Dr. Mark Gordon** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

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Sincerely yours,

Submitter : **Ms. Sarah Seitz** **Date: 08/17/2007**

Organization : **Ms. Sarah Seitz**

Category : **Individual**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

It is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rule for repairs performed on the same day as the Mohs procedure or for multiple Mohs lesion excisions performed on the same day. Following are some concerns regarding the proposed changes to the Medicare 2008 Fee Schedule:

" This proposal will negatively impact Medicare beneficiaries access to timely and quality care and application of the Multiple Procedure Reduction Rule will not likely generate significant cost savings and may paradoxically increase the cost of providing care to these patients.

" By removing the exempt status of the Mohs codes, Medicare beneficiaries access to timely and quality care will be effected. Application of the proposed rule to a second tumor treated on the same day will mean that reimbursement for the second procedure does not cover the cost of providing the service. This will affect Medicare beneficiaries disproportionately, since the incidence of skin cancers peaks in Medicare-age patients, who are most likely to have multiple tumors.

" Patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors. Many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma.

" When Mohs procedures are performed with higher-valued repairs such as flaps or grafts, application of the MPRR to the Mohs codes will result in reduced reimbursement for Mohs that doesn t cover the cost of the procedure. Likewise, for lower-valued repairs such as intermediate and complex layered closures, which are the most commonly performed repairs, reduced reimbursement will not cover the cost of the repair.

" Because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate.

Submitter : Dr. Pavel Gatynya **Date:** 08/17/2007

Organization : Dr. Pavel Gatynya

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would like to support the proposal of increase medicare anesthesia payment. The current system does not take into account not only inflation, but basic expenses in health care as well. The formula, desined a long time ago for anesthesia payment, is completely outdated. We cannot sustain anesthesia coverage when year after year payment is going down and expenses are up. We want fair payment for anesthesia services.Thank you.

Submitter : **Dr. Sean Halligan** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Submitter : Dr. Lloyd Ramby **Date:** 08/17/2007

Organization : N. Lake Houston Chiropractic Centers

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Please abolish the recommendation that reimbursement would no longer be allowed for X-rays taken by a non-treating physician such as a radiologist and used by a Doctor of Chiropractic to determine a subluxation. These X-rays, if needed, are integral to the overall treatment plan of the Medicare patients and it is ultimately the patient that will suffer should this proposal become standing regulation.

Submitter : **Date: 08/17/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I work at the front desk of a physical therapists office, so we hear many complaints and worries when a patient comes into schedule an appointment. We also get alot of questions asked about our facility and others. Our facility is not physician owned. I feel facilities that are physician owed do not care as much about the quality of care a patient receives. We have had many complaints from our patients who have went to a physicianed owned clinic. Alot have been from the front desk personel being rude and unhelpful to the therapists being too rough and hurting them. The patients have said they have tried to tell the therapists and they don't listen. They have came back to us very upset sometimes in tears. I feel a physicians owned clinics are more in for the money then to make a patient better. As well we have heard of physicians forcing a patient to go to their clinic and not letting them know they have a choice of where to go. Patients have told them that they want to go somewhere else and they still set them up with their clinic. I don't feel you should force a patient or trick a patient into going to a certain facility. Patients should not fear their physicians, they are suppose to be there to help them and listen.

Submitter : **Dr. Michael Hibbard** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

Issue Areas/Comments

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Sincerely yours,

Submitter : **Dr. Thomas Isaacson** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

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Sincerely yours,

Submitter : **Dr. Paul Meyer** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Submitter : Mr. Tom Burton **Date:** 08/17/2007

Organization : Indian Hills PT

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I appreciate this time to express my concerns. As a practicing clinician I receive a number of patients who have received PT at their doctors' office. The therapy is usually delivered by a back office staff person and consists of short timed modalities. No evaluation is performed usually. After 8-12 visits of unskilled care, I am referred the patient. The normal response from the patient is nobody ever did treatment like this before. The patients usually get better quickly and wonder why their doctor insisted that they receive treatment at his office. I have "no comment", but realize the reason is financial gain. If it were to get the patients better to return them to their pre-injury function, they would have been seen by a licensed therapist at the doctor's office. But this may make doing therapy in their office very expensive.

I have had physicians ask what is the minimum staffing necessary if they were going to do PT in their office. The question never comes as what type of staffing will I need to get my patients better.

Physicians often comment that their exposure to PT is only hours while in school versus years that I went to school. Their knowledge on treatment plans to restore function is minimal and their knowledge on contraindications of mdailities/procedures is minimal to nonexistent. This puts the patient at risk. According to CPT billing codes a licensed staff member needs to be delivering/supervising the treatment and in physician offices this is not occurring.

If this is how PT is to be delivered at a physician office, then it needs to stop. There is an obvious conflict of interest.

MD's are not allowed to own a pharmacy due to conflict of interest. PT is prescribed as are medications. The patient, who trusts their doctor, will follow their recommendations and go to wherever the doctor recommends. The patient is not made aware of the direct interest the doctor has in the financial side of the PT treatment. it is my understanding the an eye doctor needs to make a patient aware that the optical prescription can be taken anywhere, but for their convenience they have put an optical department in their office. Doctors are not voicing this to their patients that they give PT to.

There are some very good and ethical POPT's around who are using PT's, and doing therapy on the "up and up". And i respect the work that they are doing because it is correct.

i do believe a POPT can exist if done ethically and in the best interest of the patient, so guidlines need to be more stringent, similar to the guidelines we as PT's need to follow with our patients.

Thank you for the chance to voice a few thoughts.

Submitter : **Dr. Glenn Zimmet** **Date: 08/17/2007**

Organization : **Dr. Glenn Zimmet**

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.

Glenn Zimmet, D.O.

Submitter : Dr. Jerry Moench **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

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Sincerely yours,

Submitter : Dr. Riyad Mohama **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

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Sincerely yours,

Submitter : **Dr. David Nagelhout** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

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Sincerely yours,

Submitter : Dr. Lewis Ofstein **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

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Submitter : Dr. Paul Olson **Date:** 08/17/2007

Organization : North Central Heart Institute

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Submitter : Dr. Christopher Paa **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

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Sincerely yours,

Submitter : **Dr. James Reynolds** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

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Organization : **North Central Heart Institute**

Category : **Physician**

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Submitter : Dr. **Date:** 08/17/2007

Organization : Dr.

Category : Physician

Issue Areas/Comments

GENERAL

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

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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. Larry Sidaway **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Sioux Falls, SD, 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 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,

Submitter : Dr. Timothy Sullivan **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Submitter : **Dr. Galen Vonk** **Date: 08/17/2007**

Organization : **North Central Heart Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Submitter : Mr. Michael Ports **Date:** 08/17/2007

Organization : Mr. Michael Ports

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Michael D Ports, MS, CRNA
Name & Credential
2001 Fringewood Dr
Address
Midland, TX, 79707
City, State ZIP

Submitter : Dr. Bruce Watt **Date:** 08/17/2007

Organization : North Central Heart Institute

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I strongly support the ban on physician self-referral. Please remove physical therapy from the in-office ancillary services exception, which will protect physical therapy services as Congress originally intended. There is ample evidence that supports the under/over utilization of physical therapy services for personal or institutional gain of the referral source. Situations where physicians receive compensation as a result of referring physical therapy services or employing physical therapist to improve their compensation creates and environment with the potential for serious abuse.

Again, it is for the best interest of the health care system (patients, insurance, doctors and physical therapists) that physical therapy is removed from the exemption to ancillary services.

Submitter : **Mr. thomas neumaier** **Date: 08/17/2007**

Organization : **Mr. thomas neumaier**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

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Sincerely,

Thomas C Neumaier CRNA

Submitter : **Miss. Kelli Walker** **Date: 08/17/2007**

Organization : **DermSurgery Associates, P.A.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

It is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rule for repairs performed on the same day as the Mohs procedure or for multiple Mohs lesion excisions performed on the same day. Following are some concerns regarding the proposed changes to the Medicare 2008 Fee Schedule:

? This proposal will negatively impact Medicare beneficiaries access to timely and quality care and application of the Multiple Procedure Reduction Rule will not likely generate significant cost savings and may paradoxically increase the cost of providing care to these patients.

? By removing the exempt status of the Mohs codes, Medicare beneficiaries access to timely and quality care will be effected. Application of the proposed rule to a second tumor treated on the same day will mean that reimbursement for the second procedure does not cover the cost of providing the service. This will affect Medicare beneficiaries disproportionately, since the incidence of skin cancers peaks in Medicare-age patients, who are most likely to have multiple tumors.

? Patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors. Many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma.

? When Mohs procedures are performed with higher-valued repairs such as flaps or grafts, application of the MPRR to the Mohs codes will result in reduced reimbursement for Mohs that doesn t cover the cost of the procedure. Likewise, for lower-valued repairs such as intermediate and complex layered closures, which are the most commonly performed repairs, reduced reimbursement will not cover the cost of the repair.

? Because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate.

Submitter : Carrie Smith **Date:** 08/17/2007

Organization : Carrie Smith

Category : Individual

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I work for a Physical Therapy office, that an orthopedic center is in the same office building (directly across the hall). These Doctors had been referring to us for years until they actually saw the business coming in through our doors and then made an offer to buy us out. When we had denied their proposal to buy us out, they went and built an office directly across the street. I have at first hand experienced hearing patient s comments, fears and how they have been treated. It is really hard to work and instruct these patients when you know the inerworkings! I am one so outraged and tired of how patients are being treated without their knowledge, most patients want to trust and have faith in their doctor. When they don't even know that their doctors has been referring to an office for over 10 years because they know that they can get the best care there and then just to get a few extra dollars in their pocket go and build an office as fast as they can, employee people as fast as they can and then do everything that they can to keep their patients away from where they know there is good quality care. On a daily basis we see patients come over with complaints on how they felt they were given ruff care and comments on how the doctors were telling them that we were closing down. We have patients that have been coming to both of our offices for years and have really enjoyed the fact that we have shared the same building plus not to mention the care that they got on both ends was exactly what they wanted. The worst thing of it all is to hear on a daily basis what was said to the patients to keep them from coming in our door. It is really sad the things that they would say just to convince patients to put that extra money in their pockets to send them to therapist that they just started working with, or even sending patients over for things that they don't even need for that extra money. I have loved working where I do simply because we do everything in our power to give our patients what they need without trying to break the bank, our therapist will work with patients that can't spend a lot of money to get them independent to doing things on their own. Patients need to know that not everything their doctor do is for their best interest and to take into consideration that they really should be treated where they are going to get the best care. I do not feel that you could honestly determine the difference of whether or not the doctor was sending a patient to their own therapy office was for the patients benefit or for their pocket. I can say I know first hand that I know doctors that will direct you right past someone they would rather be doing your care just to make their new office a successful one. I also would think that this would be a big flare for the insurance companies who are tired of being scammed, how can they really tell the difference either. Patients please know that after you see the doctor it is up to you to find good care I would only trust a referral from a doctor now if it was directing me to an office that did not benefit their own needs. Remember who you choose to get care from is your choice!!!

Submitter : **Dr. Alan Kaplan** **Date: 08/17/2007**

Organization : **Dr. Alan Kaplan**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment.

CMS-1385-P-6359-Attach-1.TXT

#6359

August 16, 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 Livonia, Michigan as part of a 4-member pathology group in a community hospital.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. 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 they do not perform.

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. Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. This is clearly not the case.

Sincerely,

Alan G. Kaplan, M.D.

Submitter : Dr. Jeff Hanes **Date:** 08/17/2007

Organization : Dr. Jeff Hanes

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

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 non-treating provider 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 for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors 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,

Dr Jeff Hanes, DC

Submitter : **Ms. Mary Bennett** **Date: 08/17/2007**

Organization : **Ms. Mary Bennett**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

I would respectfully request that physicians's should not be able to provide physical therapy services in their office. The potential for over utilization of these services is increasingly apparent in stories told to me by individuals who were referred for numerous PT visits and basically had a PT or PTA watch them do exercises that could have easily be done at home.

I also have had patients tell me that even though they have received therapy from a PT in the past who was not associated with the physician's office, the physician basically tells the patient that they would prefer the patient to get PT in the physician's office as the PT who worked there was much better. This leaves the patient thinking that they have to go to the PT in the physician's office or they might not get the best care. Often the patient feels that their oroginal PT was just as good or if not better than the one seen in the physician's office.

Thank yu for consideration and please close the loophole in the Stark referral for profit, Thank you, Mary Bennett PT, MA, GCS

Submitter : **Ms. Jeanne Borgen** **Date: 08/17/2007**

Organization : **Ms. Jeanne Borgen**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Jeanne L Borgen MS CRNA
1408 Inspiration
New Franken WI 54229

Submitter : Mr. Thomas Joslyn **Date:** 08/17/2007

Organization : Mr. Thomas Joslyn

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk JD,
I am writing to please encourage you to finalize the proposed Anesthesia payment fee schedule that is proposed to bring the payment up for Anesthesia Services. This is vital to our profession and certainly only fair, for the services that we provide. Our payment for services has been undervalued for a long time! If this proposal is not finalized, it will have a devistating effect on our profession. Where else today can you go and tell the person who is working on your car, or home, ect; that you will only be paying them a fraction of what they have billed for their services. I'm sure that you get the point, Please finalize this proposal for all the hardworking CRNA's in America. We provide over 75% of all the anesthetics in the US. Please help us. Thanks for your consideration. Sincerely, Thomas H Joslyn CRNA, MS

Submitter : Dr. Arturo Espinoza **Date:** 08/17/2007

Organization : austin chiropractic concepts

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

August 17, 2007

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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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 for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors 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,

Arturo Espinoza DC
512 302 4773

Submitter : **Mr. Seth Harnden** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Seth Harnden, SRNA

413 Bramblewood Dr.
Nashville, TN.
37211

Submitter : Scott Yeager **Date:** 08/17/2007

Organization : University of Vermont

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I would like to comment regarding the recommendation to bundle CPT 93325 into 93307 without alteration in the RVU value of the bundled codes. As a pediatric cardiologist, we deal with widely varying anatomic and physiologic substrates and manage these patients through multiple interventions, most of which change the anatomy and physiology. We use color Doppler extensively throughout the exam, and make critical clinical decisions based on our interpretation of the findings. The evaluation and management of complex congenital heart patients has always been undervalued and under reimbursed when compared to the adult patient. This proposal will exacerbate that inequity. Please consider exemption of this bundling when accompanied by the congenital or pediatric modifiers.

Submitter : Dr. Frank Rizzo **Date:** 08/17/2007

Organization : Delaware Valley Anesthesia Associates

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I can not understand why medicare wants to further reduce payments to ASCs when they are already paid less than Hospitals. All this would do is to drive medicare patients back into the Hospital. Thus, medicare would go up. They must pay ASCs an amount that is reasonable for them not to lose money on medicare patients

Submitter : **Dr. Morteza Gharib** **Date: 08/17/2007**

Organization : **Dr. Morteza Gharib**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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 : Mrs. Susan Love **Date:** 08/17/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment.....
(elec. signature)
Susan Cozette Love
4925 South Pratt
Springfield MO 65804

CMS-1385-P-6369-Attach-1.PDF

6369

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Mr. Kenneth Kron** **Date: 08/17/2007**

Organization : **Physical Therapy Plus**

Category : **Physical Therapist**

Issue Areas/Comments

Impact

Impact

Physical Therapy Plus
200 Rt 57, Suite 1
Phillipsburg, NJ 08865

August 17, 2007

Re: CMS-1385-P

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 the 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,

Kenneth Kron, MPT, CSCS

Submitter : **Date: 08/17/2007**

Organization :

Category : **Other Technician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

It is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rule for repairs performed on the same day as the Mohs procedure or for multiple Mohs lesion excisions performed on the same day. Following are some concerns regarding the proposed changes to the Medicare 2008 Fee Schedule:

? This proposal will negatively impact Medicare beneficiaries access to timely and quality care and application of the Multiple Procedure Reduction Rule will not likely generate significant cost savings and may paradoxically increase the cost of providing care to these patients.

? By removing the exempt status of the Mohs codes, Medicare beneficiaries access to timely and quality care will be effected. Application of the proposed rule to a second tumor treated on the same day will mean that reimbursement for the second procedure does not cover the cost of providing the service. This will affect Medicare beneficiaries disproportionately, since the incidence of skin cancers peaks in Medicare-age patients, who are most likely to have multiple tumors.

? Patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors. Many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma.

? When Mohs procedures are performed with higher-valued repairs such as flaps or grafts, application of the MPRR to the Mohs codes will result in reduced reimbursement for Mohs that doesn t cover the cost of the procedure. Likewise, for lower-valued repairs such as intermediate and complex layered closures, which are the most commonly performed repairs, reduced reimbursement will not cover the cost of the repair.

? Because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate.

Submitter : **Date: 08/17/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

I am a practicing nurse anesthetist (CRNA) and urge support on the Centers for Medicare & Medicaid Services proposals to increase the valve of anesthesia services. This ia a very important step as to maintain and continus services to our increasingly ageing population. I have seen many of my experienced and able collegues leave the areas of practice which handle Medicare and Medicaid (because of increasing medical problems and low reimbursement) and move to more substainable areas of reimbursement with more healthy patients-ie plastic surgery.
CRNA's have long been a staple in providing excellant anesthesia care and services and I would not like to see this history interrupted because of under funding. Please act in a responsible manner and increase the funding for these programs for the anesthesia care.
Thank you for you time.

Carol Rydel, CRNA

(505-623-0759)

Submitter : Mrs. Heidi Vehko Jackson **Date:** 08/17/2007

Organization : DermSurgery Associates

Category : Individual

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

It is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rule for repairs performed on the same day as the Mohs procedure or for multiple Mohs lesion excisions performed on the same day. Following are some concerns regarding the proposed changes to the Medicare 2008 Fee Schedule:

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Patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors. Many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma.

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Because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate.

Submitter : **Ms. Vicki Richards** **Date: 08/17/2007**

Organization : **Ms. Vicki Richards**

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)

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.

Vicki Richards

Submitter : **Ms. Mirta Monquin** **Date: 08/17/2007**

Organization : **Ms. Mirta Monquin**

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

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Thank you for your consideration of this serious matter.

Mirta Morquin

Submitter : **Dr. William Spina** **Date: 08/17/2007**

Organization : **San Francisco Surgery Center**

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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Thank you for your consideration of this serious matter.

William Spina MD
San Francisco, CA

Submitter : Matthew Mabie **Date:** 08/17/2007

Organization : MD Group / Hometown Pharmacy

Category : Pharmacist

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

I am the co-owner of 13 pharmacies in the Southern part of Wisconsin. We have 2 large HMO's in our area that have recently upgraded their medical software to EPIC systems that account for about half of our daily volume of new prescriptions. These providers almost exclusively fax all their new prescriptions to our pharmacies from their EPIC software. Our company as a whole fills 600k scripts per year. During that year we will recieve roughly 200k new prescriptions, with about half of those attributed to the HMO's mentioned above. Being open roughly 300 days per year that amounts to about 333 prescriptions per day that will now have to get to the pharmacy some other way if this rule continues as written. This will certainly increase patient wait times at almost all pharmacies in our area, not just our own, because of this rule. Nursing homes would have a much more difficult time communicating with pharmacies about new and changing medications thereby possibly delaying essential care to these fragile people. It will make it much more difficult for patients to get new prescriptions to the pharmacies, thereby allow for more chance that somebody could go without their medication for days because they could not get to the doctor office to pick up a prescription. There is also a greater chance for error because prescriptions will either have to be phoned in or hand written by the doctor. This increases the chance for transcription errors, pronunciation errors by staff not adequately trained to phone in essential information about these prescriptions. This rule would also increase the chance that records at physician offices would not be as clean because of lack of notations about phoned in or written prescriptions because there was not an electronically generated file placed in their chart. I think this rule needs to be delayed if not completely removed. As secure as all our fax machines are, there is little chance for error or fraud with these faxes. Most physician offices will get to the e-prescribing sooner or later, let not force them to do it sooner if they are not ready for it. Many smaller independant pharmacies are not ready for e-prescribing because there are currently no MD offices with this capability, so this would cause a severe hurdle in the delivery of pharmacy and medication related healthcare. Again, please remove this rule or delay it so it will allow MD offices and health systems to implement e-prescibing when they are comfortable with the process, not when some congressionalmember or some legislator thinks it should be done.

Submitter : Dr. **Date:** 08/17/2007

Organization : Dr.

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am writing to request that the file code CMS-1385-P not be passed. This code would hinder many of the elderly from receiving much needed care due to their financial incapibilites. Please take into consideration the elderly, these people could be your mother or father.

Submitter : **Miss. Greta Wiedemann** **Date: 08/17/2007**

Organization : **Miss. Greta Wiedemann**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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This increase in Medicare payment is important for several reasons.

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Sincerely,

_____
Name & Credential
_Greta Wiedemann, SRNA_____
Address
_221 S. Oak Knoll Ave. #202_____
City, State ZIP
Pasadena, CA 91101

Submitter : **Dr. David Maguire** **Date: 08/17/2007**

Organization : **Jefferson University Hospital**

Category : **Individual**

Issue Areas/Comments

Impact

Impact

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.

David P. Maguire, MD
Executive Vice Chairman
Department of Anesthesiology
Jefferson Medical College
Thomas Jefferson University
G 8490
111 S. 11th Street
Philadelphia, PA 19107
215-955-2799
David.Maguire@jefferson.edu

Submitter : Mrs. Denise Eisel **Date:** 08/17/2007

Organization : AANA-American Association of Nurse Anesthetists

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-6381-Attach-1.PDF

6381

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

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Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Dr. Craig Berlinberg** **Date: 08/17/2007**

Organization : **Group Anesthesia Services, 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

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Thank you for your consideration of this serious matter.

Sincerely yours,

Craig D.Berlinberg, M.D.
Group Anesthesia Services, Inc.
Los Gatos, CA

Submitter : **Ms. Rhonda Pingleton** **Date: 08/17/2007**

Organization : AANA

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Rhonda K. Pingleton MSN, CRNA
1063 Viewpoint Dr.
Centerville, OH 45459

Submitter : Mr. James Chambers **Date:** 08/17/2007

Organization : American Association of Nurse Anesthetist

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I'm writing to support the CMS proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the conversion factor by 15% in 2008 compared with current levels.(72FR38122, 7/12/2007) If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetist as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

Submitter : **Richard Hrezo** **Date: 08/17/2007**

Organization : **Banner Lassen Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Ms. Norwalk:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,

Richard J. Hrezo, CRNA
465-930 Hanlon Lane
Janesville, CA 96114

Submitter : Mr. Jason Rusznak **Date:** 08/17/2007

Organization : Concorde Therapy Group

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician self-referral has grown in expedential numbers over the last 4 years in Ohio. It has reduced the amount of business in one of our facilities by 50%! In addition, patients are instructed by their physicians to drive to great lengths to get to their facilities when one of ours may be closer to their home. The physicians tell the patients that they 'want to keep an eye' on them, when in fact the physician may not even be in the building. I openly oppose physician self-referral as it directly effects many other business owners and is only a way for physicians to increase their declining revenue. It is not in the patient's best interest nor that of any payors.

Submitter : Dr. Peter Jones **Date:** 08/17/2007

Organization : Dr. Peter Jones

Category : Physician

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

I am writing a commentary concerning the 2008 PQRI proposed measure # 2 that states 'LDL control for Type 1 and 2 diabetes'. I am an academic physician in preventive cardiology, and I am board certified in clinical lipidology, and served as President (2005-2006) of the National Lipid Association (NLA). I strongly encourage physicians to follow consensus guidelines, and in that regard, I consider the National Cholesterol Education (NCEP) Adult Treatment Panel (ATP) III report (2001) and update (2004) to be the state of best practice in targeting lipid levels for the prevention of cardiovascular disease. The ATP III considers LDL cholesterol as the primary target of treatment based on an individual's risk, and most likely, this serves as the rationale for the measure # 2 wording. It is also important to remember that the ATP III considers other lipids/lipoproteins, such as triglycerides and HDL cholesterol, as contributors to CHD risk. With that in mind, the ATP III has recommended that after the LDL goal has been achieved with therapy in high risk subjects, and for those who persist with triglycerides > 200 mg/dL, that the non-HDL cholesterol becomes the secondary target of treatment. People with Type 2 diabetes are much more likely to have hypertriglyceridemia, and are therefore more likely to need a non-HDL target. The non-HDL cholesterol is a simple calculation, total cholesterol - HDL, and as such, requires the measurement of those levels. Since the calculation is used when triglycerides are > 200 mg/dL, a physician needs to have the complete lipid profile available. The ATP III has set goals of therapy for LDL and non-HDL, but not for triglycerides and HDL. They recommend that physician discretion be used to decide how to reduce the non-HDL through lifestyle change and/or medications. I also understand that there are proposals to use a complete lipid panel for people with chronic kidney disease (CKD), with which I completely agree, because CKD frequently produces elevated elevated triglycerides, and the majority of CKD individuals have diabetes. Therefore, I strongly encourage CMS to add 'LDL and non-HDL' control to measure # 2 of 2008 PQRI, and allow a complete lipid panel to be performed in all people with diabetes.

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The potential for fraud and abuse exists whenever physicians are permitted to refer to physician owned physical therapy practices.Physicians who own physical therapy practices have financial incentive to refer patients to the practices they have invested in and to overutilize those services for financial gain. Elimination of PT as a designated health service under the in-office ancillary service exception would significantly reduce CMS' programmatic abuse, over utilization of PT service, and enhance the quality of patient care. The in-office ancillary services exception has created a loophole that has resulted in the expansion of physician owned arrangements that provide physical therapy services. Because of Medicare referral requirements, physicians have a captive referral base of physical therapy patients in their offices.

The private PT practitioner who needs a referral to treat a patient is now in competition with the persons who write the referrals. This a losing proposition for all physical therapists. We are trained health care professionals in our field and yet physicians are being permitted to profit from our profession as the result of loopholes! Physician supervision is not needed to administer PT and more and more physicians are using the reassignment of benefit laws to collect payment to circumvent incident-to requirements-yet another loophole!

Stop the abuse by physician owned PT practices!!! Remove PT from the permitted services under the in-office ancillary exception. Allow physical therapists to take their profession back. Stop those who are not licensed to practice physical therapy from being allowed to refer unto themselves and own another health care providers discipline. Stop the referral for profit. If you cannot own a physical therapy practice because you are not licensed to practice the same then why haven't the loopholes been addressed to stop this behavior.

Submitter : **Dr. Clarkson Driggers** **Date: 08/17/2007**

Organization : **Mountainside 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

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 population.

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 : ERIC RISOVI **Date:** 08/17/2007

Organization : ERIC RISOVI

Category : Physician

Issue Areas/Comments

GENERAL

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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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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 : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist with a lengthy career providing services through hospital settings, I have noticed an alarming trend in the proliferation of physician-owned P.T. practices. It has been my experience that those physicians who begin involvement in this business venture suddenly become very interested in prescribing P.T. for their patients, though previously had sent limited referrals for outpatient P.T. . It has also been my experience that those physicians typically fail to educate their patients re: the patient's right of choice in a provider for their rehab service needs, most often giving the patient a script and telling them to go see the therapist with whom they have business involvement. It is my strong opinion that CMS would be wise to remove the provision of physical therapy services from the "in-office ancillary services" exception to the federal physician self-referral laws as a way to prevent overutilization of such services and to prevent likely abuse. Thank you for considering my input on this very important matter.

Submitter : **Mr. Robert Knorr** **Date: 08/17/2007**

Organization : **Tapestry Medical, Inc.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

Dear Ms. Norwalk:

The following comments refer to ? II.B.2.b.(iii) of CMS-1385-P as it relates to the Resource-Based Practice Expense (PE) RVU Proposals for CMS Billing Codes G0248 and G0249.INR home monitoring helps prevent death and disability from under or overdosing warfarin.

My company, Tapestry Medical is one of only three national providers of Home INR Monitoring services. Tapestry has worked with CMS on policy, procedural and payment issues since before the National Coverage Decision (CMS-190.11) was implemented in 2001. Over the years we have worked with medical experts to help us define and provide a quality service. We have invested substantial resources to ensure proper utilization and fair payment for this benefit. We have substantial monetary investments in INR monitoring equipment. Our business plan is based on the expectation that CMS will continue to provide a fair and reasonable allowance for these services described under HCPCS code G0248 and G0249. The proposed 50% reduction to G0248 and 30% to G0249 would result in below a payment rate below our cost. Accordingly, if adopted these reductions will prevent us from offering these services to Medicare beneficiaries in the future.

Earlier this month I submitted a comment (#192952 on August 6, 2007) that explains the proposed RVU calculation for G0249 services is significantly understated due to a miscalculation related to the INR equipment. The miscalculation did not consider that the unit of service allowance for G0249 is based on 4 INR tests, not one.

Since submitting my earlier comments I have become aware of comments submitted by Jack Ansell, M.D. of Boston University School of Medicine, a key opinion leader in the field of INR Monitoring. As a recognized authority in the field of anticoagulation management Dr. Ansell was instrumental in helping CMS evaluate the initial coverage for Home INR Monitoring.

Currently the cost of the INR Monitor (Equipment Code EQ031) is amortized on a per test basis in code G0249 (four tests reported as one unit of service). In his comments Dr. Ansell offers an alternative approach. He recommends that CMS move the entire cost of the INR Monitor into the G0248 (initial demonstration) allowance. I support Dr. Ansell s recommendation. Each INR monitor is dedicated for use by a single beneficiary. Most of the meters are only used by one beneficiary: a meter rarely is reused when a patient discontinues home testing or dies. By capturing the entire cost of the INR monitor upfront, CMS would eliminate the annual 11% interest cost it captures in the in the G0249 allowance and would no longer pay for a fully amortized INR monitor in perpetuity.

If for whatever reason CMS is unable to immediately adopt Dr. Ansell s recommendation, I want to reiterate my concern that the proposed time in use for the home monitor equipment (of 1,440 minutes) referenced in section II.B.2.b.(iii) is only 1/4th of the appropriate time. The proposed time in use (Time NF) did not account for the fact that one unit of G0249 service is based on four INR tests, not one. The correct time calculation for a unit of service is 5,760 minutes (i.e. 1,440 minutes per test times four INR tests per unit of service).

Finally, Dr. Ansell recommends that CMS require the beneficiaries to receive in person (face to face) training conducted by a qualified trainer. I strongly support these recommendations.

Sincerely,

Robert J. Knorr
Chief Executive Officer
Phone: 925.606.4998

Submitter : **Dr. Mehul Jarecha** **Date: 08/17/2007**

Organization : **Mehul Jarecha, DC**

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 non-treating provider 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 for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors 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,
Mehul Jarecha, DC

Submitter : Mr. Robert Coate **Date:** 08/17/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-6394-Attach-1.DOC

#6394

August 20, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

- First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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Additionally, if CMS' proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America's 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency's acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Robert A. Coate, CRNA
1581 Whispering Pines Dr. #8
Seaside, OR 97138-7772

Submitter : **Ms. Michelle Walker** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Michelle L. Walker, RN, SRNA
1635 Nesbitt Lane
Madison, TN 37115

CMS-1385-P-6395-Attach-1.DOC

#6395

August 21, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Michelle L. Walker, RN, SRNA
1635 Nesbitt Lane
Madison, TN 37115

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been in private practice in Delaware since 1981. During this time, I have seen physician owned physical therapy practices and unethical arrangements with MDs put a lot of good, honest and ethical PTs out of business. Several physicians in the area offer "in-office ancillary services" in which they bill for physical therapy that is provided by nurses/ aides/ athletic trainers/ or exercise physiologists but not by licensed Physical Therapists! Most of my past patients that have received this form of treatment have found it to be ineffective and costly to Medicare. Several have had surgery (extremely costly to Medicare) which may have been avoided if they had received proper treatment by a licensed PT.
Hopefully, CMS will remove physical therapy from the "in-office ancillary services" exception to the federal physician self-referral laws! Thank you for your consideration.