CMS-1385-P-8290

Submitter : **Mr. RICK WINTERS** **Date: 08/27/2007**

Organization : **American Association of Nurse Anesthestists**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:

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,

_Rick L. Winters, C.R.N.A.____________________
Name & Credential
_1539 Silent Hollow____________________
Address
_San Antonio,Tx. 78260____________________
City, State ZIP

CMS-1385-P-8291

Submitter :

Date: 08/27/2007

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-8291-Attach-1.DOC

#8291

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 : **Miss. Kelli M. Roy** **Date: 08/27/2007**

Organization : **Miss. Kelli M. Roy**

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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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-8293

Submitter : **Dr. David Nisbett** **Date: 08/27/2007**

Organization : **Michigan Association of Chiropractors**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385 P proposes denial for reimbursement for x-rays taken when the referring physician is a chiropractor. This is blatant discrimination to the chiropractic profession and should not even be considered for passage. The chiropractor is not in any way profiting from these xrays and often times they DO reveal underlying problems. I personally do not take x-rays of patients unless there are obvious reasons. I do know many general practitioners that order x-rays at the drop of a hat, only to have them come back with the obvious age appropriate degenerative findings. Please do what you can to prevent this measure from proceeding. Thanks!

Submitter : **Dr. Andrew Deck** **Date: 08/27/2007**

Organization : **Eastside Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Mr. Kuhn and CMS:

Prohibition of under arrangements rule will prohibit the provision of that are provided to a hospital through a joint venture in which urologists have an ownership interest, (such as radiation therapy or lasers). This will be detrimental to patient care because of access to these services are expensive in our community and across the country. In addition, CMS has taken efforts through a variety of different regulations through the years to eliminate duplication of services. If CMS or Congress were to prevent or further limit the ability to Joint venture with hospitals or other practices it may create an environment that would induce physicians to provide more services in-house under the practice exclusion . Each practice group will buy their own equipment or subject patients to return to the more costly and inefficient hospital providers.

We understand the importance of striking a balance between eradicating fraud and abuse and promoting efficiency and protecting patient access to care. As a urologist, these regulations, if implemented would have a negative effect on innovation, efficiency and patient access to care. Please consider suggested changes and withdraw these proposals.

CMS should not be considering making significant changes to Stark rules on an annual basis or for inclusion in the Physician Fee Schedule. Too many financial and business arrangements, legal contracts and services are involved to be altered on a yearly basis or through a piecemeal approach. In sum, the proposed rule creates two levels of uncertainty: (1) significant lack of clarity within the specific proposals themselves; and (2) general instability due to the prospect of annual changes to Stark.

Sincerely,
Andrew Deck, MD

Submitter : **Dr. Gerard Jansen** **Date: 08/27/2007**

Organization : **Jansen Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

Please allow us, Doctors of Chiropractic, to continue with referring for X-Ray procedures. Our scope, in the individual states, allows taking and interpreting under our license. Why would medicare want to waste our patient's time and monies involved with our referring to another primary care physician?

The reason we started referring out medicare X-Rays is because our local M.D.s were tired of us asking them to look at the patient and order films. They sponsored us to get local hospital - limited - privileges.

I believe it would be a mistake to drop our ability for direct referral of films.

While I am at it... I believe medicare would save additional monies if chiropractors were allowed to order other studies that require a specialist to follow, ie... an aneurism discovered on plain films requires a CT or Ultrasound to further understand the problem. Standard of care requires a review by the cardiologist. They want the study upon first consultation. We by license (education) understand this. Save the step.

Most of our local M.D.s understand our patient's welfare is our concern as is theirs.

Thanks you,

Gerard A. Jansen, D.C., L.Ac.

CMS-1385-P-8296

Submitter : **Dr. David Haataja** **Date: 08/27/2007**

Organization : **Harrison Family Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: "TECHNICAL CORRECTIONS"

The proposed rule dated July 12th 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 ro to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine that 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 a 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,
David A. Haataja, D.C.

CMS-1385-P-8297

Submitter : Mrs. LISA PRIDDY **Date:** 08/27/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I STRONGLY FEEL THAT CRNA'S SHOULD BE ADEQUATELY REIMBURSED FOR MEDICARE PATIENT CARE. PROVIDING SEDATION AND MONITORING OF SPECIAL PROCEDURES REQUIRES EXTRA TIME AND KNOWLEDGE. OUR JOB IS ESSENTIAL FOR THE WELL BEING OF ALL PATIENTS AND FACILITATES THE PHYSICIAN THROUGHOUT THE PROCEDURE. THIS CARE SHOULD BE DEEMED IMPORTANT ENOUGH TO BE PAID FOR. LISA PRIDDY

CMS-1385-P-8298

Submitter : **Dr. Scott Gillin** **Date: 08/27/2007**

Organization : **Anesthesia Service Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-8298-Attach-1.DOC

#8295.

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.

CMS-1385-P-8299

Submitter : Dr. Paul Malek **Date:** 08/27/2007

Organization : Memorial Healthcare System

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 27, 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 Hollywood Florida as part of a private Pathology practice of 20 Pathologists providing Anatomic and Clinical Pathology Services for Memorial Healthcare System, a 1700 bed tertiary healthcare system in the Fort Lauderdale area of South Broward County, Florida.

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,

Paul Allen Malek MD
Chief of Pathology
Medical Director of Laboratory Services
Memorial Healthcare System

CMS-1385-P-8300

Submitter : **Dr. James Hogg** **Date: 08/27/2007**

Organization : **Hogg Chiropractic Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Technical Corrections

In reference to CMS-1385-P, the recommendation that reimbursement will no longer be allowed for a non-treating physician such a radiologist and used by a Doctor of Chiropractic to determine a subluxation.

The Chiropractic x-ray is an integral and important part of the diagnosis process for many of my patients! Medicare still lists subluxation seen on x-ray as accepted PARTS diagnostic procedure. It is important for the health and safety of my patients that reimbursement for x-rays on a chiropractic referral be maintained.

Please reject recommendation CMS-1385-P.

Thank you,

James Hogg, D.C.

CMS-1385-P-8301

Submitter : **Dr. Joseph St. Geme**

Date: 08/27/2007

Organization : **Duke University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-8301-Attach-1.DOC

#8301

August 25, 2007

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

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

To CMS:

I am writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350 when provided together.

As the chairman of an academic department of pediatrics, I am concerned about this proposed change for the following reasons:

1. I do not believe the appropriate process has been followed with respect to this change. After significant interaction and research between the RUC and the appropriate specialty societies (in this case The American College of Cardiology and the American Society of Echocardiography), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that the list of above echo codes be bundled as well with the 93325.

   This new code is fully expected to address any outstanding issues relative to Medicare utilization of 93307, and has been analyzed at length by appropriate national medical societies, the CPT editorial panel, and the RUC. However, as a result of this proposed regulatory action by CMS, we are faced with resolving, in an accelerated timeframe of less than two months, an issue that directly impacts a distinctly non-Medicare population - namely, pediatric cardiology practices - and which is normally addressed over a multi-year period. Further, because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

2. The surveys performed to set the work RVUs for almost all of the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVUs are reflective of a focus on the cost of the technology and not the advances in care

that have been developed as a result of the technology. Particularly among pediatric cardiologists, much needed new surveys would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component and a lesser technology component.

This shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) initiative to develop and implement an echo lab accreditation process. The focus of this initiative is on process, meaning work performed, and not on the technology associated with the provision of echocardiography services. This echocardiography accreditation initiative will be mandated by many payors within the next year.

In 1997 there were specific echocardiography codes implemented in CPT for congenital cardiac anomalies to complement the existing CPT codes for echocardiography for non congenital heart disease. "The codes were developed by the CPT Editorial Panel in response to the American Academy of Pediatrics and the American College of Cardiology's request to delineate more distinctively the different services involved in *assessing* and *performing* echocardiography on infants and young children with congenital cardiac anomalies." (*CPT Assistant 1997).*

Consistent with this, I have significant concern with the continued approach (of which this bundling proposal is an example) of placing adult and pediatric patients in the same grouping when it comes to evaluation of the work associated with providing care to these significantly different patient populations. Because the adult cardiology population is much larger than the pediatric population, the RVUs for procedures that are common to both are established exclusively using adult patients as the basis. The work and expense associated with providing care to pediatric patients is not considered. The inaccuracies that result from this approach can be linked to anatomical differences between pediatric and adult patients (size, development, etc.) as well as the basic issue of getting a child to be still while performing complex imaging procedures.

CPT Code 93325 describes Doppler color flow velocity mapping. This service is typically performed in *conjunction* with another echocardiography imaging study to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities.

Pediatric echocardiography is unique in that it is frequently necessary to use Doppler flow velocity mapping (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 for the pediatric population stating that Doppler color flow

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

velocity is "... even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." It should also be recognized that Doppler flow velocity mapping is an essential medical service being provided to patients with congenital and non-congenital heart disease in the pediatric population.

3. I believe that this change would adversely impact access to care for pediatric cardiology patients. Pediatric cardiology programs provide care not only to patients with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for pediatric cardiology services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed change to bundle 93325 with other pediatric cardiology echocardiography codes be implemented.

   Thus the effect of this change on pediatric cardiology programs throughout the country will be an increase in the need for subsidies from already resource-challenged children's hospitals and academic programs, or a significant increase in Medicaid reimbursement for the proposed bundled services, in order for pediatric cardiology patients to have the same access to care and resources that they do today.

I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

Sincerely,

Joseph W. St. Geme, III
Professor and Chairman of Pediatrics

CMS-1385-P-8302

Submitter : Dr. Monica Riesner **Date:** 08/27/2007

Organization : University of Michigan Health System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. William McGivney** **Date: 08/27/2007**

Organization : **National Comprehensive Cancer Network**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Drug Compendia

Drug Compendia

Comments from the National Comprehensive Cancer Network are attached.

CMS-1385-P-8303-Attach-1.DOC

#8303

Your Best Resource in the Fight Against Cancer

CMS Proposed Rule 1385-P

Comments on ***DRUG COMPENDIA***

L. Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

National Comprehensive Cancer Network   August 27, 2007

Background:

The National Comprehensive Cancer Network (NCCN) is pleased to offer comments specifically related to the "Drug Compendia" section (pages 38177-38179 and page 38219) of this proposed rule.

The NCCN is an alliance of 21 of the world's leading cancer centers. The NCCN is a not-for-profit organization as are all NCCN member institutions. The NCCN and its members share with our colleagues at the Centers for Medicare and Medicaid Services (CMS) the goal of improving the quality, effectiveness, and efficiency of health care available to all patients. Specific to our organizational missions, the NCCN strives through a variety of programs to improve care for patients with cancer, including the approximately 50% of all patients diagnosed with cancer every year in the United States who are Medicare-eligible.

Summary:

The NCCN applauds the establishment of a formal process by CMS for ongoing review of the listing of the Compendia to make sure that the listing satisfies the needs of Medicare beneficiaries. However, the NCCN is concerned that the "Process for Determining Changes to the Compendia List" is unnecessarily lengthy. We strongly urge CMS to revisit this process and seek ways to significantly shorten its length.

The NCCN agrees with the conclusion as stated on page 38219 that the current proposals related to Compendia will have a "negligible" cost to the Medicare program. Also, the NCCN believes that the compendia recognized under Part B should be used under Part D in order to assure the availability of appropriate and effective drugs and biologics through decision-making processes (e.g., coverage, formulary development) for Medicare beneficiaries.

The NCCN strongly recommends that CMS take immediate action to recognize the ***NCCN Drugs and Biologics Compendium*** as a mandated reference for coverage determinations regarding the

appropriate use of drugs and biologics in cancer care by CMS and its intermediaries and carriers. All major oncology groups and other major national organizations outside the oncology community have determined that such recognition of the NCCN Drugs and Biologics Compendium is critically needed. The Medicare Evidence Development and Coverage Advisory Committee (MedCAC) has given the NCCN Compendium the best scores on all desirable characteristics, including markedly better scores than for the two currently recognized compendia. NCCN recommendations for appropriate care are widely recognized and applied as the standard for clinical policy in the United States in both the academic and community practice settings. Recognition of the NCCN Compendium will serve to appropriately link the scientific, evidence-based judgments of experts from across the United States to evidence-based coverage policies that will assure access to appropriate and effective therapies for Medicare beneficiaries with cancer.

Finally, the NCCN believes that the various components of the discussions and process established and carried out by CMS, to date, have been helpful to the NCCN in improving the content and format of the NCCN Compendium. The NCCN looks forward to official recognition of the ***NCCN Drugs and Biologics Compendium*** by CMS and ongoing collaborations on behalf of patients whom we serve.

Specific Comments:

Definition of a Compendium:
The NCCN agrees with the CMS definition (page 38178) of a Compendium that includes "a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment". Clearly, the area of cancer treatment is one of the most rapidly advancing areas of Medicine. The success of our nation's biomedical research enterprise has provided many new FDA-approved drugs and biologicals in recent years. Additionally, research pipelines are replete with innovative therapies. For these drugs and biologicals, the use of agents beyond the FDA-labeled indications is a common and appropriate practice when based upon sound, scientific evidence integrated with expert judgment. As such, the determination of coverage policies regarding the appropriate use of drugs and biologicals in cancer treatment is one of the more challenging areas for CMS and its intermediaries and carriers. The availability of a comprehensive, evidence-based, and up-to-date cancer-specific compendium will support the establishment of coverage policies that will help to assure that Medicare beneficiaries have access to and receive appropriate and effective drug and biological treatment.

Broad Accessibility of Compendium Recommendations and Information:
The NCCN is in full agreement with the CMS statement that (page 38179) "broad accessibility by the general public to the information contained in the compendium may assist beneficiaries, their treating physicians or both in choosing among treatment options" is an important consideration in the recognition of a Drugs and Biologicals Compendium for the Medicare program.

Negligible Cost to the Medicare Program:
The NCCN agrees with the conclusion as stated on page 38219 that the current proposals related to Compendia will have a "negligible" cost to the Medicare program.

Formal Process for Listing of Compendia and Its Length:

The NCCN applauds the establishment of a formal process by CMS for ongoing review of the listing of the Compendia to make sure the listing satisfies the needs of Medicare beneficiaries. However, the NCCN is concerned that the "Process for Determining Changes to the Compendia List" is unnecessarily lengthy. It would appear that the earliest that the CMS process could finalize a revision of the list of compendia utilized for coverage determinations of drugs and biologicals for cancer treatment is September, 2008. We strongly urge CMS to revisit this process and seek ways to shorten its length. CMS has spent over two years in deliberations and discussions and study of this important issue, and we applaud you for the significant investment of time and resources in this effort. This time and effort has resulted in a clarification of direction as it relates to this critical issue. It is incumbent upon CMS to act on this issue in a very timely fashion. Broad support from many sources indicates the substantial urgency for doing so.

CMS Discretion in Changing Compendia Listing:
We agree with the statements on page 38179 that indicate that CMS internally may generate a request to change the compendia listing "at any time". As CMS has noted, all major organizations in the cancer community (e.g., American Society of Clinical Oncology, American Cancer Society, Oncology Nursing Society, Association of Community Cancer Centers, and those outside e.g., American Medical Association, National Patient Advocate Foundation) have indicated the serious need to add a cancer-specific compendium now to the Compendia listing. All these national organizations and many more have formally requested immediate action by the Secretary of Health and Human Services (HHS) to recognize the NCCN Compendium as a mandated reference, in addition to the existing references, for the determination of coverage policies for drugs and biologicals under the Medicare program.

Consistency of Benefits and Access under Part B and under Part D:
The NCCN believes that the compendia recognized under Part B also should be used under Part D in order to assure availability of appropriate and effective drugs and biologics through decision-making processes (e.g., coverage, formulary development) for Medicare beneficiaries. Adding compendia to Part D is extremely important to the cancer community due to the increasing prevalence of oral cancer chemotherapeutics. Of the last 10 chemotherapeutic agents approved by the FDA, six were for administration by the oral route. Of the more than 400 agents in clinical development, more than half are orally-administered agents.

The NCCN Drugs and Biologics Compendium:

The NCCN agrees with the excellent conclusions of the March 30, 2006 meeting of the MedCAC on the Compendium issue in the area of cancer treatment. The MedCAC identified and listed the desirable characteristics (page 38178) of a compendium. Again, it is important to note that the NCCN received the highest score in the aggregate from the voting members on each of the characteristics identified. On the most important issue of "how confident are you that compendia adhere to evidence-based criteria and processes in making recommendations", the NCCN Compendium received the best score at 4.5 (out of 5) compared to 3.58 for the USPDI (the next best to the NCCN Compendium). Given the critical circumstances for Medicare beneficiaries with cancer, it is imperative that CMS and its intermediaries and carriers base coverage determinations on a compendium that is evidence-based and up-to-date. The NCCN Compendium clearly meets these two important characteristics.

The NCCN has responded directly to CMS requests to add specific features to the Compendium.

- The NCCN Drugs and Biologics Compendium is freely searchable by generic name, brand name, disease indication, pharmacologic class, histology, and route of administration.
- The NCCN is revising its landing page for the Compendium to display the listing of agents in alphabetical order by generic name. This feature will be available by October 15, 2007. The aforementioned expansive search capabilities of the Compendium will remain totally intact so that users who wish to search by brand name, disease indication, or another key word category will be able to continue to do so.
- The NCCN is in the process of linking all listed drugs and biologicals in the NCCN Compendium directly to the latest FDA labels available in order to provide appropriate information on the pharmacological characteristics, mechanisms of action, adverse reactions, drug interactions, warnings, and cautions of the agents in the Compendium. This feature will be available by October 15, 2007.

The NCCN Drugs and Biologics Compendium is available free of charge to all visitors to the freely-accessible NCCN web site (www.nccn.org). The NCCN agrees that such broad accessibility will help inform decisions by patients and their clinicians regarding the appropriateness of treatment options. As a not-for-profit organization, we seek to fulfill our educational mission to improve patient care through the development and dissemination of sound, scientific, evaluative information such as that contained within the NCCN Drugs and Biologics Compendium.

Given that the NCCN Compendium is freely accessible, end-users may check at anytime to see if updates have been made to certain drugs or biologics. The NCCN will be glad to proactively transmit all changes to the Compendium to CMS and to its intermediaries and carriers. We understand the plethora of issues being reviewed at any one time and stand ready to find ways to facilitate awareness of important changes to the NCCN Compendium.

On page 38178, it is noted that in the MedCAC meeting "it was reported that oncologists do not rely on compendia when making treatment decisions, relying instead on published treatment guidelines, clinical trial protocols, or consultation with peers". The NCCN, based upon our experience, agrees with this conclusion about most compendia. However, it is interesting to note that of the 9,103 registered users of the NCCN Compendium, 3,346 (37%) are physicians and 1,713 (19%) are nurses. Five hundred three (503) registered users characterize themselves as being with managed care companies.

We believe that the availability (free of charge) of the NCCN Clinical Practice Guidelines in Oncology and the NCCN Treatment Guidelines for Patients as resources complementary to the NCCN Drugs and Biologics Compendium provides the full context in which to make appropriate treatment decisions along the complete continuum (e.g., medical oncology, surgery, radiation, palliation) of cancer care. The ability of end users to move from the Compendium to the Guidelines facilitates a more specific evaluation of treatment choices involving drugs and biologicals in the context of multidisciplinary care. Additionally, the NCCN is developing a library of standard chemotherapy order templates for use by all clinicians that will specify chemotherapeutic/biological regimens listed in the NCCN Clinical Practice Guidelines in Oncology and the NCCN Compendium

with dosing information, monitoring and hold parameters, supportive care, and safety instructions to further assure appropriate use and to maximize safety and effectiveness. The availability of the entire suite of NCCN information products including the NCCN Treatment Guidelines for Patients, along with the NCCN Compendium, will help to inform the decision-making processes of Medicare beneficiaries and support the evaluation of the quality of cancer care.

We commend our colleagues at CMS for the attention and effort you have dedicated to this important issue. We appreciate the opportunity to provide our perspective and comments. We stand ready to help in any way that we can to improve the quality of information available for all forms of decision-making under the Medicare Program.

William T. McGivney, Ph.D.
Chief Executive Officer
National Comprehensive Cancer Network
500 Old York Road
Suite 250
Jenkintown, PA 19046
215-690-0255
mcgivney@nccn.org

CMS-1385-P-8304

Submitter : Dr. Kyle McKamey

Date: 08/27/2007

Organization : HealthZone Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a 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,

Kyle McKamey, DC

CMS-1385-P-8305

Submitter : **Dr. Robert Ardis** **Date: 08/27/2007**

Organization : **SMDC**

Category : **Critical Access Hospital**

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 an anesthesiologist who occasionally works in a critical access hospital.

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 RUCs 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 Ardis MD

Submitter : **Dr. Jonathan Pomales** **Date: 08/27/2007**

Organization : **Puerto Rico Chiropractic Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Re: "Technical Corrections"
The proposed rule dated July 12 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 diagnosis testing, i.e.MRI or for a referral for the appropiate specialist.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the cost for the patinet 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 theatening 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, agian, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Dr.Jonathan Pomales
Chair Health Insurance Comittees
Vice-President
Puerto Rico Chiropractic Association
Past President Puerto Rico Board of Chiropractic Examiners

CMS-1385-P-8307

Submitter : **Mr. Bubby Fischer** **Date: 08/27/2007**

Organization : **Baton Rouge Cardiology Clinic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Please see attachment

CMS-1385-P-8307-Attach-1.RTF

#8307

August 27, 2007

Herb B. Kuhn, Deputy Administrator (Acting)
Centers for Medicare and 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: Proposed Revisions to Payment Policies Under the Physicians Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

On behalf of Baton Rouge Cardiology Clinic and our 11 individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the ***"Resource-Based PE RVU's"*** section of the above referenced July 2, 2007 Proposed Rule. We are specifically concerned with the 2008-2010 PE RVU's established for non-facility outpatient cardiac catheterization procedure codes and the significant negative impact that could result for our practice and our patients if these values are finalized for the 2008 Physicians Fee Schedule.

We are a 12 physician practice with 11 cardiologists and one radiologist. We see over 23,000 patients a year with a 120 person staff. We are located in Baton Rouge, LA.

Martin "Bubby" Fischer is a member of the Cardiovascular Outpatient Center Alliance (COCA) and as such we have actively been involved in the work that COCA has accomplished this year to collect and submit direct and indirect cost data to the AMA's Practice Expense Review Committee (PERC) of the Relative Value Scale Update Committee (RUC). Unfortunately, this process did not allow all of COCA's data to be considered and resulted in PE RVU recommendations to CMS that severely undervalued the direct and indirect costs associated with providing these procedures to our patients.

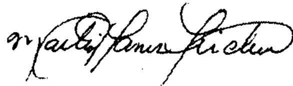
It is apparent from the July 2, 2007 Proposed Rule that CMS has accepted the RUC recommendations without considering the detailed direct cost information

that COCA provided to CMS in May 2007. The PE-RVU values set out in the July 2 Proposed Rule would result in a draconian cut in reimbursement for cardiac catheterizations performed in practice or IDTF locations. For example, if the 2007 conversion factor is applied to the technical component of the primary three CPT codes for a Left Heart Cath (93510TC, 93555TC, and 93556TC) the reimbursement in 2008 would be cut by **32%** and when fully implemented the total reimbursement would be reduced by **49%**. These reductions would undoubtedly result in the closing of the majority of non-facility outpatient cardiac catheterization labs in the country forcing all patients who now benefit from improved access and lower costs into more acute hospital settings.

We request that CMS review the additional cost data provided by COCA and establish PE RVU's for outpatient cardiac catheterization procedures that more reasonably reflect the direct and indirect costs of providing these procedures. If the proposed RVU's are allowed to stand, the outcome will inevitably that will cost the Medicare program more in direct APC payments **and** Medicare patients more in higher deductibles and co-insurance.

Thank you for this opportunity to comment on this important issue.

Sincerely,



Martin "Bubby" Fischer

Martin "Bubby" Fischer
Administrator
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Toll Free 800-624-7875
Fax 225-769-9029
Pager 225-233-0000

CMS-1385-P-8308

Submitter : **Bob Ardis** **Date: 08/27/2007**

Organization : **Health Care Consumer**

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. It is interesting that CMS does not propose to compensate for the mis-payment that has occurred over the last 15 years. Perhaps they could talk to the IRS into a similar philosophy.....

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Bob Ardis

Submitter : **Dr. Ronald Manteuffel** **Date: 08/27/2007**

Organization : **Center Line Chiropractic Life Center P.C.**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposal dated July 12 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!

It may be true that an x-ray may not be necessary to detect a spinal subluxation, the films do provide the treating doctor with a plethora of information including but not limited to: degenerative changes of the spine, fracture, joint malformation, short leg syndrome, potential cancer issues, osteoporosis etc.

Denying access to x-rays puts the patient and doctor at risk!

I strongly urge you to table this descriminatory proposal. I have never heard of such a proposal being thrown at the medical profession. It's time for the descrimination to stop!!!

CMS-1385-P-8310

Submitter : **Dr. Brian Sayler** **Date: 08/27/2007**

Organization : **Sibley Family & Sports Chiropractic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider your future plans for x-ray referral for the use of Chiropractic care. This change will greatly affecti the outcomes on Medicare patients because they will be reluctant to take care of their spinal health because CMS said that x-rays were not a needed diagnostic tool for the use of Chiropracitc.

Sincerely,

Dr. Brian J. Sayler

Submitter : **Dr. Nicholas Kambouris** **Date: 08/27/2007**

Organization : **Washington Hospital 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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Nicholas Kambouris MD, PhD
Director, Cardiac Anesthesiology
Washington Hospital Center
Washington, DC 20010

CMS-1385-P-8312

Submitter : **Mr. Jonathan Baird** **Date: 08/27/2007**

Organization : **Select Physical Therapy**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Please take another look at this issue (The loophole allowing Physicians to refer to themselves for profit) because I know of Several Physicians that are referring to themselves for their own profit. Another way to look at it would be: If a Physician owned a pharmacy, they would send their patients to their own pharmacy even though their might be a cheaper, or better one just down the street because the physician would profit from it.
Many patients (when it comes to matters of their health) will accept their doctor's word as 'gold' because they are doctors. Rather than looking into the situation themselves.
If a physician tells a patient 'you should go to my physical therapist' the patient will very rarely go against the word of their doctor. Or even look into the other options that are out there. This creates a situation with a high potential for 'over utilization' of physical therapy services because the physician is profiting by their own referral.
If you would like to discuss this matter, please don't hesitate to contact me:
Jonathan Baird PT: 303-814-2865

CMS-1385-P-8313

Submitter : **Ms. Jan Wortham** **Date: 08/27/2007**

Organization : **Ms. Jan Wortham**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am a CRNA in Arkansas. We are reimbursed less here than 48 other states for medicare and in addition took a 8.7% cut Jan 1 2007. Please increase our rates so we can afford to take care of our fellow Arkansans on Medicare

CMS-1385-P-8314

Submitter : **Dr. Carmen Clemenson** **Date: 08/27/2007**

Organization : **Clemenson Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Referring to File Code CMS-1385-P "Technical Corrections". I believe that this motion should be abolished as it would hinder needy Medicare patients from obtaining x-rays for their chiropractic physician to view. X-rays give chiropractors vital information necessary for proper treatment. Unfortunately, Medicare already does not allow for chiropractors to be reimbursed for x-rays taken in office, this already makes the patient burden with yet another visit to obtain an x-ray. This motion will make it more difficult for chiropractors to do their jobs, and for patients to obtain the proper care that they need and deserve.

Submitter : **Mr. Jeffrey Black** **Date: 08/27/2007**

Organization : **Mr. Jeffrey Black**

Category : **Attorney/Law Firm**

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. Penny Black** **Date: 08/27/2007**

Organization : **Mrs. Penny Black**

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.

Submitter : **Dr. Richard Snyder** **Date: 08/27/2007**

Organization : **Home**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

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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. Curt Jacob** **Date: 08/27/2007**

Organization : **Dr. Curt Jacob**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

To Whom It May Concern:
Please know that I am in strong opposition to the proposed rule dated July 12, 2007, that will result in non-reimbursement for x-rays taken by a non treating provider and used by a Doctor of Chiropractic to determine a subluxation.

X-ray films are necessary to rule out pathology and to analyze the vertebral integrity of the spine. Senior citizens have often had a lifetime of spinal degeneration and possible other spinal problems that may be a cause of concern when considering the appropriateness of chiropractic care. If they have to pay out of pocket for these necessary films, they may opt to forgo chiropractic care and continue with dangerous drugs to treat their symptoms. Many seniors are already taking way too many medications and the potential for serious side effects increases the other costs that medicare must pay for.

Please table this proposal.

Sincerely,
Curt A. Jacob, D.C.

CMS-1385-P-8319

Submitter : Dr. David Rice

Date: 08/27/2007

Organization : Assn. of Freestanding Radiation Oncology Centers

Category : Health Care Professional or Association

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

See attachment

CMS-1385-P-8319-Attach-1.DOC

#8319

August 27, 2007

Herb Kuhn
Deputy Administrator
Centers for Medicare and 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; Proposed Rule; CMS-1385-P

Dear Mr. Kuhn:

The Association for Freestanding Radiation Oncology Centers (AFROC) is delighted to have the opportunity to submit these comments on the proposed revisions to Medicare's payment policy under the Physician Fee Schedule (PFS) for CY 2008, which was published on July 12, 2007 in the Federal Register (the "Proposed Rule"). AFROC is an association of freestanding radiation oncology centers owned primarily or in large part by radiation oncologists. These centers provide high quality radiation oncology services to cancer patients throughout the country.

We applaud CMS for its decision to retain the medical equipment and interest rate assumptions used in the calculation of practice expense relative value units (PE-RVUs) unchanged this year. We concur with CMS's rationale for leaving the interest rate unchanged. We also concur that there is insufficient reliable data on equipment utilization. The minimal data that has been collected generally has focused on medical imaging, such as MRI and CT. There is undoubtedly some equipment for which a 50% utilization rate is too low; however, it is equally clear that there is some equipment for which a 50% utilization rate is too high. We urge CMS to retain the current equipment utilization rate until a uniform and consistent methodology can be devised to determine the appropriate utilization rate for all equipment reimbursed through PE-RVUs.

Moreover, the equipment utilization assumption should not be modified unless and until CMS revises its allocation methodology for indirect practice expenses. Indirect practice expenses are allocated among physicians' services largely on the basis of physician work RVUs (W-RVUs) and, since TC have no physician work RVUs, the current allocation methodology on its face severely disadvantages TC services. CMS decided to allocate indirect practice expenses largely

{D0155599.DOC / 2}

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based on W-RVUs despite objections from TC providers largely because the remaining indirect practice expenses are allocated based on direct expenses, and TC services have extremely high direct expenses. However, to the extent that use of a higher equipment utilization assumption results in lower direct expenses attributed for TC services, the basis of CMS's defense of the current indirect PE allocation formula is no longer valid, and the issue should be re-examined.

This point is best illustrated by examining the result of CMS's decision to accept AFROC's argument that freestanding radiation oncology centers were under-represented in the prior radiation oncology PE/hr calculation. As the result of this decision, the IPCI for radiation oncology was increased by about one-third, which might have been anticipated to result in a significant increase in the PE-RVUs for all radiation oncology services. Ironically, though, even though it was the inclusion of a greater proportion of freestanding centers that was responsible for the increase in the (IPCI), because indirect PEs are allocated largely on the basis of W-RVUs, the PE-RVUs allocated to TC services were basically unchanged. This illustrates how skewed against TC services the current indirect PE RVU allocation formula is.

We also request that CMS review the direct cost inputs for CPT 77336. The PE-RVUs for this service will be reduced by an additional 18.3% reduction from 2007 to 2008 and by an aggregate of 62.2% by 2010. The current practice expense inputs for this code, which were considered by the PEAC/RUC in 2002, are outdated, and we encourage CMS to work with the affected radiation oncology community to revise these inputs as soon as practicable to reflect the true direct costs of providing these important physics services.

Finally, we understand that the malpractice RVUs assigned to technical services have not been revised since their initial assignment. CMS states that these services have never been reviewed because of the lack of accurate data on the cost of professional liability insurance for technical staff. We would be delighted to assist in collecting this data for freestanding radiation oncology centers.

We appreciate the opportunity to provide these comments. If you have any questions, please do not hesitate to contact our Washington counsel, Diane Millman, at 202-872-6725 (dmillman@ppsv.com).

Sincerely yours,

David Rice, M.D.
President, AFROC